East and North Hertfordshire NHS Trust
Trust Board - Public Meeting

Meeting Room 1 / MS Teams

3 November 2021 10:30 - 3 November 2021 12:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	10:30
2	Apologies for absence		
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. Draft minutes of the previous meeting - Public Tr... 7	Chair	
6	Patient Story For discussion	Chief Nurse	10:45
7	Chief Executive's Report For discussion 7. CE Board Report - November 2021.pdf 19 7. Appendix A.pdf 23	Chief Executive	11:00

#	Description	Owner	Time
8	Board Assurance Framework For discussion 8. Board Assurance Framework.pdf 27	Associate Director of Governance	11:10
9	Integrated Performance Report For discussion 9. IPR M6.pdf 57	All Exec Directors	11:15
10	Ambulance Handovers For discussion 10. Ambulance Handover Delays.pdf 103	Chief Operating Officer	
11	System Collaboration Report For discussion 11. System Collaboration Report.pdf 115	Deputy CEO	12:00
12	Responsible Officer Annual Report For approval 12. Responsible Officer Revalidation Report.pdf 119	Medical Director	12:10
13	Sub-Committee Reports		12:15
13.1	Finance, Performance and People Committee Report to Board For information 13.1 a) FPPC Board Report 29 September 2021.pd... 133 13.1 b) FPPC Board Report 27 October 2021.pdf 137	Chair of FPPC	
13.1.1	FPPC Annual Review and TOR For approval 13.1.1 FPPC Annual Review 2020-21.pdf 141 13.1.1 Appendix 2 - Terms of Ref.pdf 149	Chair of FPPC	

#	Description	Owner	Time
13.2	Quality and Safety Committee Report to Board For information 13.2 a) QSC Board Report 28 September 2021.pdf 155 13.2 b) QSC Board Report 26 October 2021.pdf 159	Chair of QSC	
13.2.1	QSC Annual Review and TOR For approval 13.2.1 QSC Annual Review 2020-21.pdf 163 13.2.1 Appendix 1- QSC TOR.pdf 171	Chair of QSC	
13.3	Audit Committee Report to Board For information 13.3 Audit Committee Board Report 19 October.pdf 175	Chair of Audit Committee	
13.3.1	Audit Committee Annual Review and TOR For approval 13.3.1 Audit Committee Annual Evaluation and Ter... 179	Chair of AC	
13.3.2	Annual Review of Standing Orders and Standing Financial Instructions For approval 13.3.2 ENHT Standing Orders and Standing Financ... 191	Director of Finance and Chair of AC	
13.4	Equality and Inclusion Committee Report to Board For information 13.4 Equality and Inclusion Committee Board Repo... 317	Chair of EIC	
13.5	Strategy Committee Report to Board For discussion 13.5 Strategy Committee Board Report 21 Septemb... 321	Chair of SC	
13.6	Charity Trustee Committee Report to Board For discussion 13.6 CTC Board Report 13 September 2021.pdf 325	Chair of CTC	

#	Description	Owner	Time
14	Actions Log For information [P] 14. Public Trust Board Actions Log.pdf 329	Trust Secretary	
15	Annual Cycle For information [P] 15. Board Annual Cycle 2021-22.pdf 331	Trust Secretary	
16	Data Pack For information [P] 16. Data Pack.pdf 335		
17	Date of next meeting 12 January 2022		12:25

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 1 September 2021 at 10.30am at the Lister Hospital, Stevenage & via Microsoft Teams Video Conferencing

Present:	Mrs Ellen Schroder	Non-Executive Director (Trust Chair)
	Mrs Karen McConnell	Non-Executive Director
	Dr Peter Carter	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Dr David Buckle	Non-Executive Director (Associate) (via conference-call)
	Mr Bob Niven	Non-Executive Director
	Mr Biraj Parmar	Non-Executive Director
	Mr Martin Armstrong	Deputy Chief Executive Officer & Director of Finance
	Mrs Rachael Corser	Chief Nurse (via conference call)
	Mrs Julie Smith	Chief Operating Officer (via conference call)
From the Trust:	Mr Tom Pounds	Chief People Officer (via conference call)
	Mr Joseph Maggs	Trust Secretary (via conference call)
	Ms Jude Archer	Associate Director of Governance (via conference call)
	Mr Mark Stanton	Chief Information Officer (via conference call)
	Dr Tim Walker	Deputy Medical Director (deputising for Medical Director) (via conference call)
Also in attendance (via conference call):	Emma Chandler	Patient Story (for item 21/082 only)
	Tom Bryan	NHS Leadership Academy
	Linda Sheridan	HCT (from 21/084)
	Eilidh Murray	Head of Communications (ENHT)
	Ebony Wood	Minute Taker (ENHT)

No	Sub-No	Item	Action
21/077		**CHAIR'S OPENING REMARKS**	
	21/077.1	Mrs Schroder welcomed everyone to the meeting.	
21/078		**APOLOGIES FOR ABSENCE**	
	21/078.1	Apologies for absence were received from Mr Jonathan Silver (Non-Executive Director), Mr Nick Carver (Chief Executive) and Dr Michael Chilvers (Medical Director).	
21/079		**DECLARATIONS OF INTEREST**	
	21/079.1	There were no declarations of interest.	
21/080		**QUESTIONS FROM THE PUBLIC**	
	21/080.1	There were no questions submitted from members of the public.	

21/081 MINUTES OF PREVIOUS MEETINGS

21/081.1 The minutes of the previous meeting were approved as an accurate record of the meeting.

21/082 PATIENT STORY

21/082.1 The Chief Nurse introduced Ms Chandler who shared her experience as an inpatient on Ward 10B.

21/082.2 Ms Chandler informed the Board that in April 2021 she was brought to the Lister by ambulance as she had become increasingly confused and drowsy. Her blood sugar was found to be high and she was admitted to the Lister although she does not remember her admission.

21/082.3 She found herself attached to various machines and catheterised however she did not feel out of control and was aware there was a team around her. She felt she could trust them and they were calm and compassionate throughout her stay. The medical team also kept her family well informed.

21/082.4 Ms Chandler met Dr Solomon and the diabetic team and Dr Solomon made it clear that he wanted to improve her health and well-being long term rather than discharge without clear diagnosis and treatment plan.

21/082.5 Post discharge, she had found the diabetes nursing team to be incredible. They were always in touch and provided advice and reassurance and Ms Chandler felt that she was listened to.

21/082.6 Ms Chandler commented that she was incredibly grateful to the NHS and felt that they had not only saved her life but also improved her quality of life.

21/082.7 Mrs Schroder expressed her delight that all had gone well and commented that she was always interested in hearing a good news story, especially in regard to communication as this was an area the Trust was working to improve.

21/082.8 The Chief Nurse agreed that Ms Chandler's positive experience around communication stood out and her experience had been shared with staff.

21/082.9 The Board thanked Ms Chandler for sharing her patient story.

21/083 CHIEF EXECUTIVE'S REPORT

21/083.1 The Deputy Chief Executive highlighted the following points from the report:

- HRH The Princess Royal visited the Lister in July to present the Butterfly Service with their Queen's Award for Voluntary Service.
- Adam Sewell-Jones had been appointed to the role of Chief Executive from 1 January 2022. It was noted that he would be attending the Trust for a number of days before he takes up the role.
- A successful thank you week for staff had been held from 5 July

with various activities across all ENHT sites. This had received positive feedback from staff. A poignant memorial service had been held that week to honour staff and patients who sadly lost their lives due to the pandemic.

- The ED would have significantly expanded capacity from March 2022 once the refurbishment was completed.
- COVID continued to be in general circulation. The numbers were not at worst-case scenario level but still remained a pressing issue for the Trust.
- The Trust's service recovery programme had made good progress with some areas returned to pre-pandemic level.

21/083.2 Mrs Schroder commented that red and yellow A&E were still running due to COVID and asked if this was creating operational inefficiencies.

21/083.3 The Chief Operating Officer responded that the Trust was focusing on ensuring IPC requirements were met. New guidance was constantly reviewed for any suggested changes. The cost pressure was included in the six point plan to review and improve all elements of the patient journey into, through and out of the emergency department.

21/083.4 Mr Niven asked about the national shortage of blood tubes. The Chief Nurse commented that the Trust had a good internal supply and further to NHSE guidance had reduced usage. The situation was reviewed on a daily basis as the Trust was keen to offer mutual aid to others if required. She noted that good oversight and patient safety was managed through the Trust's gold command structure.

21/083.5 Mr Niven further asked whether there had been a change in the age profile of COVID patients. The Chief Nurse noted anecdotally that the population of COVID patients tended to now be younger and also those who had not received both vaccinations.

21/084 INTEGRATED PERFORMANCE REPORT

21/084.1 Mrs Schroder commented that the board had received a draft version of the M4 Integrated Performance Report and the finalised version would be published online shortly.

21/084.2 **Quality and Safety**

The Chief Nurse highlighted the following:

- The increase in Serious Incidents was due to the national request to record hospital-onset COVID cases. Patients and loved ones have had duty of candour applied when appropriate.
- The total number of cases of COVID averaged 35-45 per day.
- The C.difficile hospital-onset numbers were slightly above the Trust's trajectory. Zero MRSA incidents had been reported. The Trust's infection control position was positive and benchmarked well with colleagues across the system.

21/084.3 **Caring Services**

The Chief Nurse commented that board members had been sighted on actions to deal with the increasing number of complaints. This was supported through the Quality & Safety Committee on a monthly basis.

21/084.4 **Effective Services**

The Deputy Medical Director noted that the main focus was on improving mortality. Figures continued to show a steady position. Crude mortality was down. The Trust was positioned 13 out of 123 acute hospitals for SHMI and maintained a sustained position. SHMI excluded COVID deaths but included deaths within 30 days of hospital admission. The Trust was an outlier for NOF deaths and the outcome of an investigation should be concluded during September.

21/084.5 Readmissions had fluctuated however there had been a fluctuation in the overall case mix which had made comparison difficult. The Trust was slightly lower than the national average on readmissions.

21/084.6 **Responsive Services**

The Chief Operating Officer drew the Board's attention to the following:

- The ED had deteriorated against the 4-hour standard national average due to demand and acuity of patients.
- Activity was slightly down in July compared to June but the numbers on a daily basis were still high. An increase in conversion had been seen, suggesting increased acuity.
- A six point improvement plan for the ED was being put into place.
- The Trust had continued to be challenged with ambulance handovers. This was not unique to ENHT, however the Trust was continually trying to improve.
- Good progress continued in relation to cancer performance and the Trust remained compliant over 62-day performance. Deep dives for tumour types continued.
- The Board remained concerned around stroke with a slight deterioration in 4-hour performance. The stroke triumvirate will report back to FPPC in September in order to understand and support the roadmap to return to a SNNAP A rating.

21/084.7 **Well-Led Services**

The Chief People Officer drew the Board's attention to the following:

- In regard to recruitment, there had been an overall increase in terms of staff in post.
- The vacancy rate had increased however this now reflected the amendment of headroom to ensure the correct distribution of substantive to bank workforce.
- Both qualified nursing and medics were ahead of target in terms

of vacancies.

- July was a challenging month for staff deployment. Bank and agency usage increased due to a rise in sickness absence and special leave (staff having to isolate).
- Staff had been supported in development and growth through the ENH Academy and quality conversations were being held with staff around their career plans.

21/084.8 Mrs Schroder commented that the number of staff on e-rostering appeared to have plateaued under the Trust's targets and that this should be kept under review. Mrs McConnell responded that a deep dive on this subject was being presented at the FPPC meeting.

21/084.9 Mr Niven commented that there had been a number of high OPEL days and asked what was behind these. The Chief Operating Officer commented that there was not one single factor. It included sustained demand at the front door, high acuity, increased average length of stay, challenges around key individuals not being available over summer. She noted however that when OPEL 4 had been declared, the Trust had managed to stand down from this level very quickly. The Trust's ability to recover and respond to OPEL 4 was in a much better place than previously. The Multi Agency Discharge Event (MADE) would highlight how things could be done differently with quick turnarounds.

21/084.10 **Sustainable Services**

The Director of Finance drew the Board's attention to the following:

- The end of month 4 reporting period showed a small modest surplus.
- The Trust had done well in terms of performance against the ERF although this may show diminishing returns as the year progressed.
- Guidance on the financial framework for the second half of year was being awaited from NHSE.

21/084.11 The Director of Finance informed the Board that there were aspirations to include more content in the Integrated Performance Report. The Chief Information Officer was working on adding digital compliance indicators. Estates and Compliance would also be integrated into the report going forward.

21/084.12 Mrs Schroder commented that she would like the executives to speak on the different points in the report and consideration could be given to including a transformational section. She was also keen to include a section on collaboration with the ICS and ICP.

21/085 PEOPLE AND OPERATIONAL RECOVERY

21/085.1 The People and Operational Recovery Report was taken as read.

21/085.2 The Chief Operating Officer highlighted the following:

- The Trust continued to perform well against ERF performance standards. It was important for services to be opened to allow

patient access. The Trust would continue to work with system partners and utilise the independent sector.

- The Trust continued to prioritise patients in order of clinical need. The 104 week breaches related primarily to T&O, Pain and Oral Surgery. Deep dives were being undertaken to understand the trajectory and actions needed to recover the position.
- A communication tool 'Consultant Connect' would be piloted in dermatology and haematology.
- Patient Initiated Follow Up (PIFU) was now live in specific specialties for selected patients.
- Flu vaccines and COVID boosters were expected to be offered to staff from September.
- The first draft of the Trust's Winter plan had been developed.
- East Imaging Network 2 had been established as a cluster of 8 acute hospitals. There were significant opportunities for enablers around radiology and imaging initiatives.
- A Multi Agency Discharge Event (MADE) was being held from 31 August to 3 September at both place and ICP level. This would focus on front door initiatives, along with promoting virtual wards and encouraging discharges.
- The ED refurbishment was progressing well and work was being undertaken with estates and facilities to realise the capital improvements. The refurbishment would include increased triage areas for ambulance offloading and a new SDEC facility.
- The Trust's 62-day cancer performance was strong at 89.8%.

21/085.3 The Chief People Officer highlighted the following points in regard to People Recovery:

- Focus continued on the different areas of the Care Support Pyramid.
- There had been an unrelenting focus to ensure minimal vacancy levels.
- There was a healthy pipeline and the Trust was continuing to look at international nurse recruitment.
- Work was being undertaken around staff rest spaces.
- Key work was being undertaken around the culture programme and a list of interventions had been developed to address the issues. The initiatives were being brought together in a coherent manner and would then be launched.
- The healthy leadership rhythm continued with training and development. Bite size sessions had been delivered. The next stage was development of a senior leadership development programme.
- The 'Here for You' service was working well.
- More requests from departments had been received to run reflective sessions.
- Mental health first aid training was rapidly moving towards the target of 1 in 30 members of staff trained.

21/085.4 Dr Carter asked if there as a sense of how many people turn up to

the A&E department who do not really need to be there.

21/085.5 The Chief Operating Officer responded that a joint audit of 200 patients had just been taken. Patients were asked how they found their way to the ED, whether they had accessed 111 or could have accessed primary care. It was noted that up to two-thirds of the patients could have been seen in an alternative healthcare setting.

21/085.6 Dr Carter noted that an issue had been raised at the QSC meeting that there were a number of international nurses who were unable to commence work as they had trouble receiving their PIN numbers. He asked if there had been any change.

21/085.7 The Chief People Officer noted that one of the reasons for the issues was there had been a larger influx of international nurses than normal. In February/March there had been 60 international nurses whereas normally there would have been a maximum of 20-30. As the numbers had reduced there was not as much of a delay being seen.

21/085.8 In relation to the MADE week, Mr Niven asked whether targets/goals had been set in order to measure the results to test the impact. The Chief Operating Officer replied that a MADE dashboard had been prepared to include key indicators and these were being reviewed each day against targets. Mrs Schroder asked if West Herts and PAH had the same targets and the Chief Operating Officer commented that three MADE events were being run and the information would be shared between the sites.

21/085.9 In regard to PIFU, Mr Niven asked what the criterion was for patient selection. The Chief Operating Officer responded that it was speciality-based and based on conversations between the consultant and patient themselves. A safety net was in place to ensure patients did not miss appointments.

21/085.10 Mr Parmar congratulated the Trust for the high volume of activity taken on recovery. He commented that there was clearly a lot more to do however it seemed that the focus was in all the right areas.

21/085.11 He asked the Chief People Officer if the Trust had a view on why the staff sickness rate was increasing, especially as there were so many wellbeing initiatives being offered. The Chief People Officer responded that there was only so far the initiatives could help as staff were tired and fatigued in a challenging environment. There was concern around the higher stress-related sickness and there had also been an increase in COVID infections. The situation was being monitored.

21/085.12 Mrs McConnell commented it was encouraging to see the high number of initiatives outlined. With winter coming and the Trust already under a lot of pressure, it was important to work closely with other parts of the system. She asked if the Trust was drawing together ways these different areas could help as winter approached.

21/085.13 The Chief Operating Officer commented that during the period of recovery, the Trust was testing out where the biggest opportunity was. During MADE week there was an effort to identify how as a system to best support patients and to enable the Trust to be in the best position for winter.

21/085.14 The Chief Nurse mentioned two other pathways which were currently a priority:

- Maternity – LMNS were starting to see real pressure on this area.
- Mental health – going into winter there was a greater need to work collectively with partners on how to manage complex patients.

21/086 WRES AND WDES REPORTS

21/086.1 The Chief People Officer presented the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports and noted that these had received scrutiny at the Equality and Inclusion Committee.

21/086.2 The following key points were highlighted from the WRES report:

- The Trust had an increasingly diverse workforce. This had changed over the last 5 years, however, it was important to note that it was not equally diverse at all levels. There was some work to do in order to meet some of the targets at the higher Agenda for Change levels.
- There was improvement in both WRES 2 (being appointed from shortlisting) and WRES 4 (non-mandatory training and CPD) although there was still work to be done.
- Reciprocal mentoring between minority ethnic staff and senior leaders was being introduced.
- Deep dives would be held at the Equality and Inclusion Committee meetings in order to review and understand talent within the organisation and how this could be developed.

21/086.3 An area that had moved in a negative direction was WRES 3 (entering into formal disciplinary processes). It had been an unusual year for complaints and incidences with a very low number through the first part of year followed by a substantial increase. The actions being taken were as follows:

- The Equality and Inclusion Committee would continue its focus on this area.
- A multidisciplinary team was being set up to review all cases that went through last year and any learning or understanding would be applied to any new cases going forward.
- A triage process was in place to review cases before they reached the formal stage as an informal resolution was the preferred option.
- Inclusion ambassadors had been in place for just over 12 months. This allowed for more diverse panels for each

interview panel. These ambassadors were now included from the very start of any recruitment including the job description and how the role was advertised. This process could also be used for WDES.

21/086.4 The following key points were highlighted from the WDES report:

- There was a low declaration of disability rate.
- There was a positive trend in terms of likelihood to appoint.
- Disability passports were being explored which could be carried with staff as they moved between organisations to highlight adjustments that may be needed.
- There would be a focus on encouraging people to be more open and talk about their disabilities. Senior members of staff would be encouraged to speak about their experiences.

21/086.5 Mrs Schroder noted that some WDES reports showed relative figures for disabled against non-disabled staff and asked if it would be possible to compare statistics for non BAME people in WRES 6, 7 and 8.

21/086.6 Mr Parmar commented that disclosure of disabilities was important but recognised that encouraging staff to do this was a challenge.

21/087 TRUST ANNUAL REPORT AND ACCOUNTS 2020/21

21/087.1 It was noted that the Trust Annual Report and Accounts had been through the approval process and was presented to the Board for information. The Deputy Chief Executive commented that it had been agreed at the AGM in June that the report would be brought to the September Board as it was not completed in time for the AGM.

21/087.2 Mrs Schroder suggested a shortened version of both the Annual Report and Quality Account be prepared to send out to GP surgeries, community groups, and others in order to raise visibility. The Head of Communications would investigate.

21/088 UNIVERSITY PARTNERSHIP ANNUAL REPORT

21/088.1 The report was taken as read. The Deputy Medical Director highlighted the following:

- The Trust was in year five of a six year partnership arrangement.
- The Trust's relationship with the university had strengthened over the last 12 months despite the challenges faced from COVID.
- The next key focus was to re-establish if the Trust could become a teaching hospital. There had been some changes, however good support was being received from the Department of Health and partners.
- There were many good news stories over the last 12 months with degree apprenticeships continuing and different ways of working.

21/088.2 Mrs Schroder confirmed that the focus would be on renewing the contract with the university when it expired and investigating what

the Trust could do about becoming a university or teaching hospital. It may no longer be possible for the University of Herts to offer ENHT hospital status because it does not have a medical school.

21/088.3 Ms Moore commented that she was pleased to see things had progressed during a difficult year. She asked how much workforce the Trust had in common in terms of people who come from the university to work at the Trust and then return to the university, and what was the quantum to learn in terms of equality and inclusion.

21/088.4 The Chief Nurse commented that her commitment with the Dean of the School of Health and Sciences would be in place regardless of the formal partnership. More shared roles were being developed and the calibre of students was exceptional. There was a commitment to give these students exposure to experiences that would assist them to become clinical academic leaders in the future. There was more that still could be done, especially with their research centre.

21/089 BOARD ASSURANCE FRAMEWORK

21/089.1 The Board received the latest edition of the BAF.

21/089.2 The Associate Director of Governance informed the Board that the Committees had reviewed all their risks. There were no items to be escalated to the Board.

21/089.3 Of the 12 risks, the Associate Director of Governance reported that six remain at a rating of 16 which was an improvement on the previous risk profiles.

21/089.4 It was noted that the Audit Committee had agreed a schedule of deep dives related to the BAF risks.

SUBCOMMITTEE REPORTS:

21/090 FINANCE, PERFORMANCE AND PEOPLE COMMITTEE REPORT TO BOARD

21/090.1 The Board received and noted the summary report from the Finance, Performance and People Committee meeting held on 28 July 2021.

21/091 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

21/091.1 The Board received and noted the summary report from the Quality and Safety Committee meeting held on 27 July 2021.

21/091.2 Dr Carter commented that discussions had been held with committee members around streamlining cover sheets and future reports in order to focus on two or three important issues. The authors of the reports would be invited to the meeting for their relevant agenda item.

21/092 AUDIT COMMITTEE REPORT TO BOARD

21/092.1 The Board received and noted the summary report of the last meeting of the Audit Committee held on 19 July 2021.

21/092.2 Mrs McConnell commented that the Value for Money Report had not been brought to the Board as it had not yet been submitted by the external auditors.

21/093 EQUALITY & INCLUSION COMMITTEE REPORT

21/093.1 The Board received and noted the summary report of the Equality & Inclusion Committee meeting held on 11 August 2021.

21/093.2 Mr Parmar asked the Board to note that the WRES and WDES reports would be published on the Trust website by 1 October 2022.

Ms Moore commented that although this was a new committee, she felt extremely energised after the last meeting. There was clearly work required to develop the data and action plan and operational barriers had been mentioned, however she welcomed the challenge.

21/094 ACTION LOGS

21/094.1 The Board received the latest version of the Actions Log.

21/094.2 In response to Minute Ref 21/066.4 on the action log where the Medical Director was asked to provide further detail regarding the breakdown of R&D activity, income, etc across MVCC and the rest of the Trust, the Deputy Medical Director informed the Board that the R&D funding was split across the two sites and the activity covered around 2,000 patients at the Lister and 300 at MVCC. A significant amount of research was undertaken at the Lister however more of the external funding is committed to MVCC.

21/095 ANNUAL CYCLE

21/095.1 The Board received the latest version of the Annual Cycle.

21/096 DATA PACK

21/096.1 The Board received the Data Pack.

21/097 DATE OF NEXT MEETING

21/097.1 The next meeting of the Trust Board will be on 3 November 2021.

_____

Ellen Schroder

Trust Chair

November 2021

East and North Hertfordshire NHS
NHS Trust

Chief Executive's Report

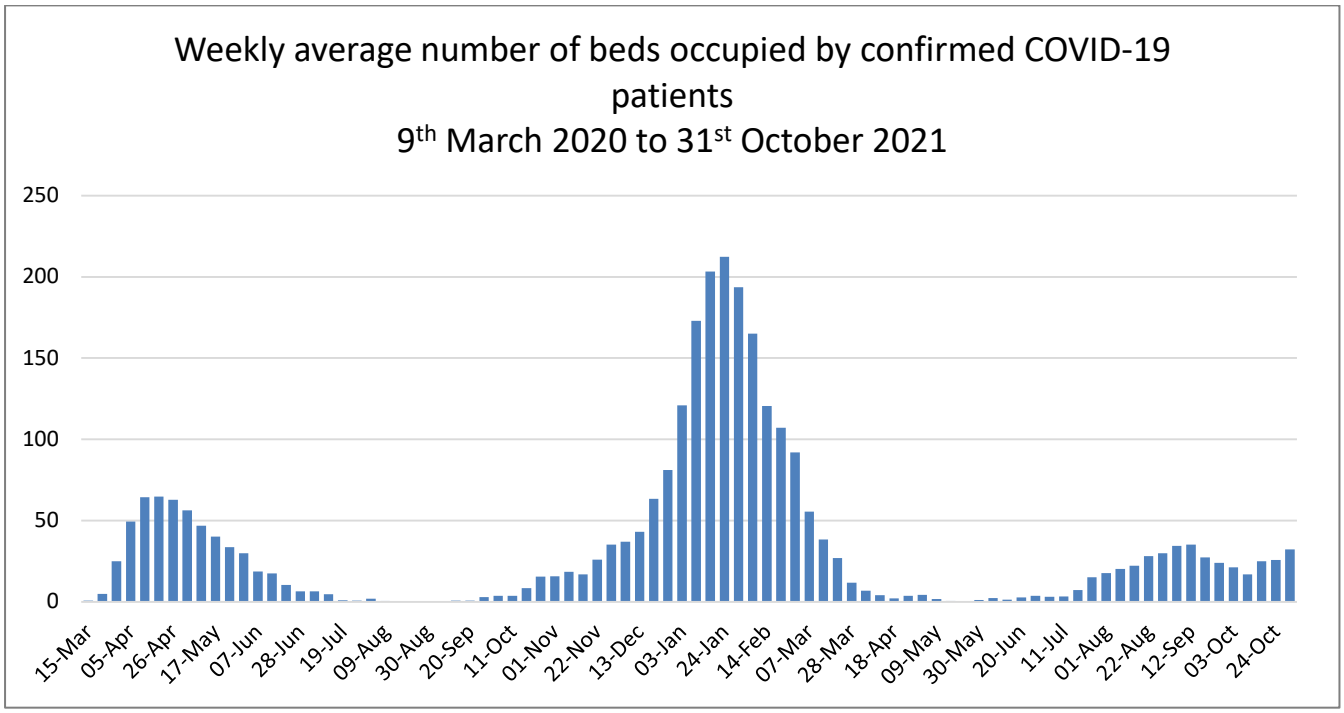
November 2021

Covid-19 Update

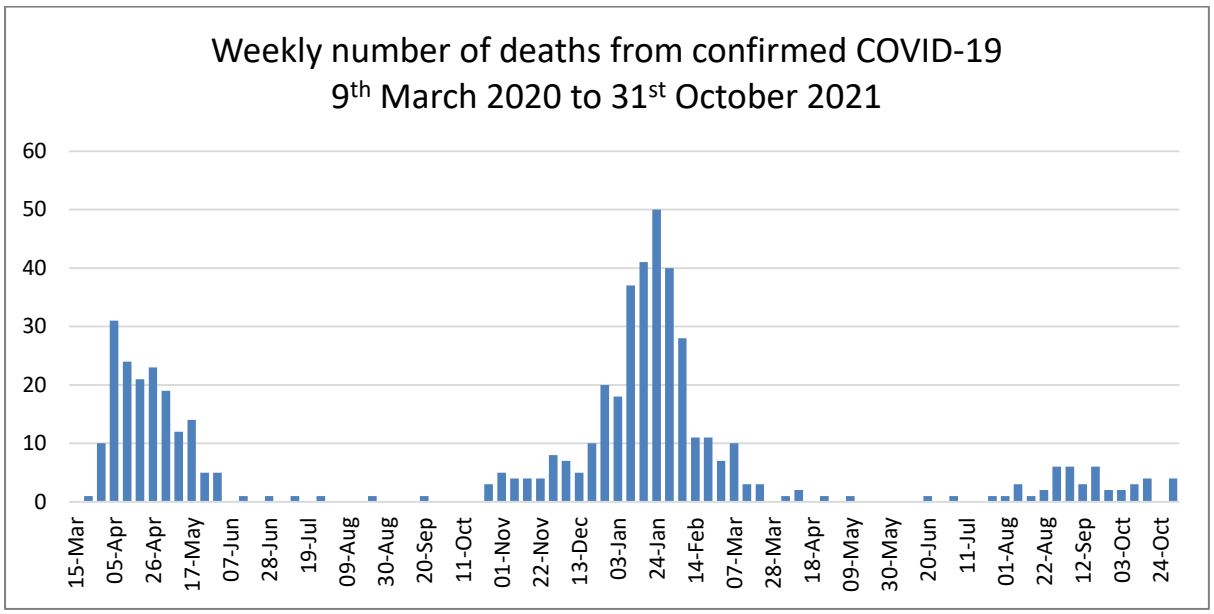
At the last public board meeting held on 1st September I reported that the Trust was treating 27 patients with Covid-19.

At the time of writing, we were treating 37 patients with Covid-19.

The table below provides an illustration of the number of patients being treated with Covid-19 over time. Whilst the numbers have not affected the level of previous surges, it is worth noting a consistent level over an extended period of time.



This table illustrates the number of patients dying with Covid-19 over time.



Whilst the vaccine programme has been a tremendous success, the attachments demonstrate the continuing challenge by Covid-19.

Addressing ambulance handover delays

Recent media coverage has highlighted the national issue of ambulance handover delays. All Trusts have been asked to take action to address severe delays. Our letter attached (see Appendix A).

The Trust has always viewed minimising ambulance delays as being extremely important albeit complex. In her report the Chief Operating Officer will highlight the actions that we are taking to reduce delays further.

Thank You

Having attended board meetings at the Trust since November 2002, this will be my last board meeting as I retire as Chief Executive in mid-December.

I would like to extend my thanks to the Chair and fellow board members, past and present, for their advice and support. I have learnt a very great deal from excellent executive and non-executive colleagues over the years and it is clear that my leadership would have been considerably weaker without their guidance.

I am grateful to system partners for the collaborative way in which they have worked with the Trust and am mindful that this will remain essential in the context of future challenges.
I do want to express my thanks to the political representatives of Hertfordshire, past and present, who have provided such sterling support to the Trust. Their willingness to seek the best interest of the Trust in serving their constituents, rather than short-term political gain, has been crucially important, especially in enabling the Trust to make vital changes to services.
I am conscious that not all Trust Chief Executives have been similarly privileged to enjoy such support.

The last 20 months has been a time when it has been an especial privilege to lead.
The COVID pandemic has brought great sadness. It has been a time when 554 patients and 2 members of staff have died of COVID (as of 29/10).

It has also been a time when the Trust's people have demonstrated great skill and character and when the support of local people has been very evident, providing great motivation.

The strength of the Trust's employees, the support of partners and encouragement of the local people will, I am sure, enable the Trust to be successful in meeting the obligations of the NHS constitution in the future.

I wish the Trust great success and am grateful for the privilege to lead that has been granted to me.

Nick Carver
Chief Executive

Classification: Official
Publication approval reference: BW1101

To: ICS Leads
Acute Trust Chief Executives
Ambulance Service Chief Executives
Acute Trust Chairs

CC: CCG Accountable Officers

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

26 October 2021

Dear colleague,

For action – Addressing ambulance handover delays

We are writing to all Trusts and ICSs regarding delays in handing over responsibility for the care of patients from ambulances to Emergency Departments, recognising that these delays can only be addressed through good system working and cross-organisational cooperation.

In the UEC Recovery 10 Point Action Plan we asked that ICSs "make sure there are robust steps in place to avoid handover delays". We know, and are grateful, that staff within your system are already working incredibly hard to resolve this problem. Given the impact on patients, we must however press to identify further solutions to eliminate all handover delays.

Handover delays

National policy has set out that handovers should take no more than 15 minutes, ensuring patients receive necessary emergency care and allowing ambulances to get back on the road responding to patients in the community.

You will be keenly aware of the risks associated with hospital handover delays.

Acute trusts should take responsibility for patients from when the ambulance arrives and ED staff are informed of arrival, regardless of the patient's exact location. In practice, there is a need for close cooperation and risk sharing between services.

Taking action to eliminate delays

All systems must take action to ensure that ambulances are not used as additional ED cubicles, and that crews are able to safely offload their patient to the care of the ED. It is important that patient safety is prioritised and as a result we emphasise that corridor care is unacceptable as a solution.

We are now asking you to work together as a system and agree what actions you would need to take to immediately stop all delays. We appreciate that this may involve some difficult choices, and that we will need to discuss and involve colleagues, including the CQC, where helpful. For ease of reference we are attaching a list of measures which we know that some of you have implemented which have demonstrated clear benefits.

Today we also are asking Trusts, and their Systems, to report the actions that they have put in place to ensure delays have been eliminated in all Board Meetings, taking time to discuss the challenges with data to support the issue. You may find it helpful to invite clinical staff from the relevant areas to join these discussions.

In addition to the above, because of the significant problems being experienced on the Lister Hospital site, we need to ask that you urgently have a conversation with your Regional Director to review the actions you may need to take to eliminate these delays. We appreciate that this is not an easy ask, as referred to above some of these actions may have implications and we may need to have a dialogue in order to find the best way forward. We anticipate that these conversations should take place w/c 1 November and will result in an agreed plan for the system.

This should not deter you from continuing to taking action to address immediate delays prior to this date.

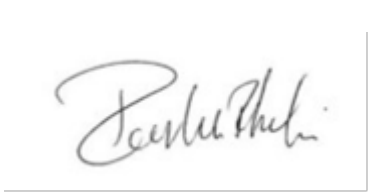
Initiatives being used in systems

The following is not exhaustive, and a combination of initiatives is likely to be most effective:

- Establish surge capacity / priority admission unit to care for patients out with ED following a decision to admit; this may require conversion of existing space, or temporary accommodation, within the acute trust to accommodate patients prior to admission to the appropriate ward
- Wherever practical implement “fit-to-sit” for patients that do not require a trolley
- Ensure early access to clinical decision-makers to enable prompt admission / discharge
- Establish additional community capacity to enable earlier discharge for patients no longer requiring acute medical care
- Increase capacity of discharge lounge to free beds earlier in the day, accompanied by rapid support from non-emergency patient transport services
- Maximise discharge through following principles within the hospital discharge and community support: policy and operating model
- Increase direct access to GP streaming, SDEC, acute frailty services and medical / surgical assessment units from ambulance crews to reduce direct ED conveyance
- Match community and mental health service capacity and demand to enable reduced conveyance to ED for appropriate patients
- Work with two-hour community crisis response teams to offer appropriate alternative pathways to an ambulance response
- Local agreement of staffing models e.g. using acute trust, ambulance service and community service staff in partnership to support surge capacity
- Making use of HALO staff to support handover of care, or working with ambulance services to explore whether Community First Responders are available to take on additional roles to support care for patients
- Work with Provider Collaboratives and ambulance services to support boundary changes and diverts, where this will help to decompress a site

We thank you for taking this necessary rapid action to address the risks associated with handover delays.

Yours sincerely,



Pauline Philip DBE
National Director for Emergency and Elective Care

Professor Steve Powis
National Medical Director

Ann Radmore
Regional Director

Agenda Item: 8

TRUST BOARD - 3 NOVEMBER 2021
Board Assurance Framework Risks 2021/22

Purpose of report and executive summary (250 words max):
The BAF 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. The Trust's strategic risks for the Board Assurance Framework 2021/22 on one page. **Appendix a.** These with the exception of removing the reference to the short term risk of spending the capital allocation for 2020/21 (Risk 4) the scope of the risks remained unchanged for 2021/22. A formal review of the strategic risks will take place in the final stages of the development of the Trust's new Organisational Strategy. An early review of this in September has not indicated significant changes. The Trust's strategic priorities and have been mapped to the Trust objectives for 2021/22 providing assurance on the coverage. **Appendix b.**

The BAF 2021/22 is completed with each of the lead directors, **appendix c,** using the revised template approved by the Audit Committee. The areas of high risk are covered in the Board Committee agenda items and papers. Any updates to the text from the previous month are highlighted in red text for ease.

At the September and October Board committee meetings is was noted that continued increase in activity and pressures in specific specialities, e.g, ED, Assessment, Maternity, Paeds, Mental Health, and Critical Care was impacting on a number of the BAF risks including Performance, Quality, People and governance. As we approach winter, competing pressures with a potential increase in Covid numbers and decrease in available workforce brings additional challenges, alongside the equally pressured system partners. The Committees discussed the various workstreams in place and mitigating actions agreed internally and with our system partners. This is monitored through our meeting structures and Executive Committee.

The Board are asked to:

- Note, the Audit Committee had a deep dive review for Risk 8 Quality**.** This was a routine deep dive as part of the assurance cycle. Discussed the impact of the backlog of activity, current activity pressures and changes to pathways in the context of quality and safety. Assurance given on the actions being taken. Also discussed Medical Director and Chief Nurse holding joint strategic session for their senior teams. This will include review of quality and safety priorities, maximising working together and supporting the divisions effectively.
- Approve the following recommendations from Finance Performance and People Committee and:
  - Risk 1 Operational Delivery: Risk level reviewed at QSC and FPPC and recommended **increasing** the risk from 16 to 20; this recognises the impact of the current operational performance/ challenges and continued challenges of activity, winter pressures, competing priorities, impact of staff sickness. FPPC received a deep dive and assurance on the Discharge Improvement Programme and Winter Planning - including internal and system wide actions/initiatives to support the mitigation of the risk. Cycle of deep dives in place.
  - Risk 3 Finance: Risk level reviewed and recommended **reducing** from 16 to 12 (at target rating) taking into account the current and forecast position including the reports on the H2 Planning Guidance and budget and H2 CIP delivery.
  - Risk 4 Capital: Discussed the risk rating and confirmed when taking into account the longer term position of access to capital it remains a 16.
- Consider the BAF and any changes or further assurance required.

Action required: For discussion		
Previously considered by: Considered at each Board and Board Committee. FPPC and QSC		
Director: Chief Nurse	**Presented by: Associate Director of Governance**	**Author: Associate Director of Governance**

Trust priorities to which the issue relates:	**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 – as noted
Any other risk issues (quality, safety, financial, HR, legal, equality): As documented under each risk

Risk Scoring Guide

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

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

Trust risk scoring matrix and grading

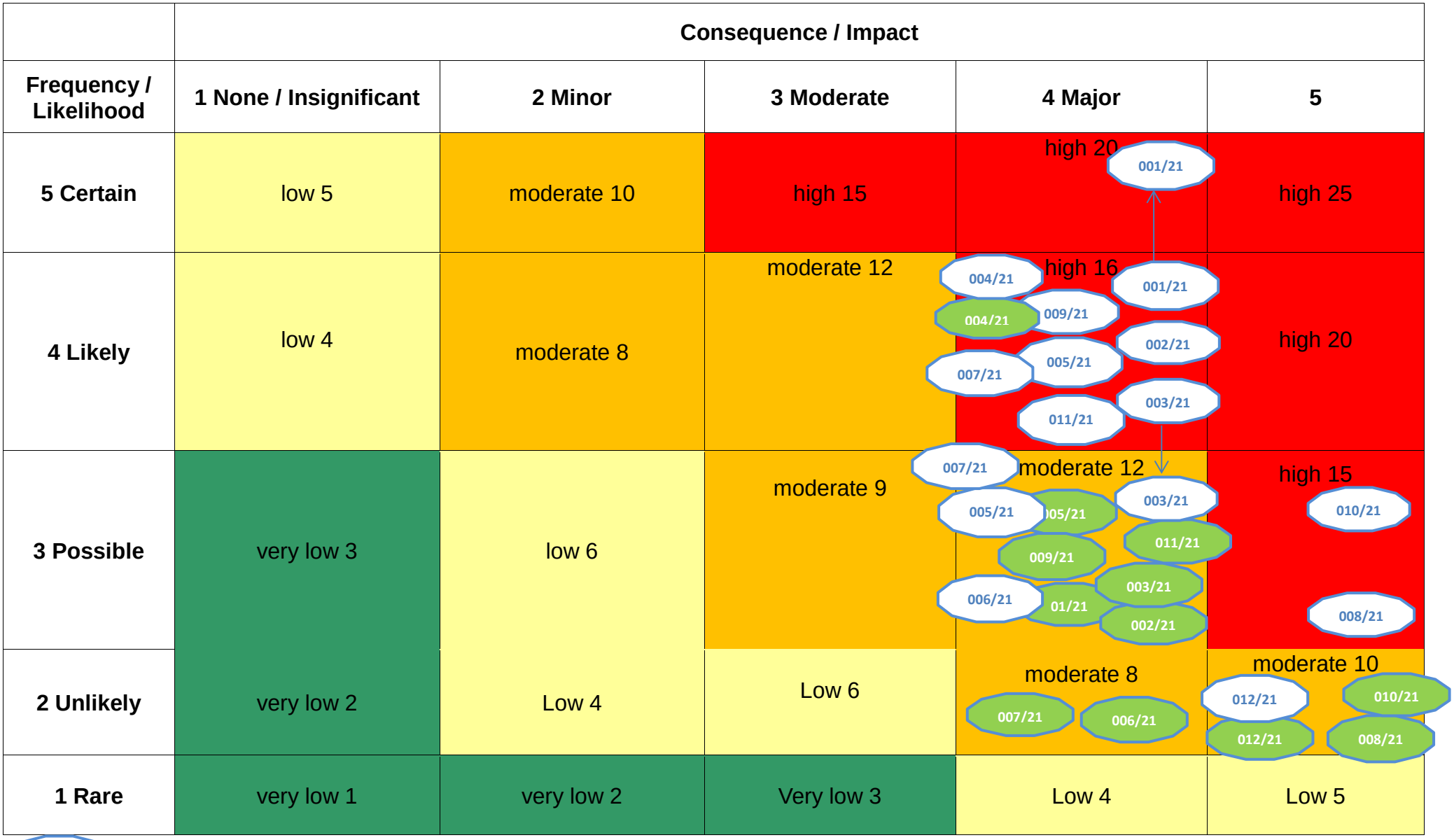
Likelihood / Impact	1 Rare (Annual)	2 Unlikely (Quarterly)	3 Possible (Monthly)	4 Likely (Weekly)	5 Certain (Daily)
Death / Catastrophe 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
None /Insignificant 1	1	2	3	4	5

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

BOARD ASSURANCE FRAMEWORK OVERVIEW

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

Board Assurance Framework Heat Map –October 2021



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

East and North Hertfordshire NHS Trust

Our Vision

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

Our Priorities

1. Quality:	2. People:	3. Pathways:	4. Ease of Use:	5. Sustainability:
R2 Workforce	R2 Workforce R8 Quality	R1 Op Delivery	R1 Op Delivery	R1 Op Delivery
R4 Capital	R9 Culture	R5 Digital	R5 Digital	R3 Finance
R5 Digital	R12 Pandemic	R6 ICP	R6 ICP	R4 Capital
R7 Governance		R8 Quality		R6 ICP
R8 Quality		R11 Pathways		R7 Governance
R10 Estates		R12 Pandemic		R10 Estates
R11 MVCC				R11 – MVCC
R12 Pandemic				R12 Pandemic

Our Objectives 2021/22 *Board approved*

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

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

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

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

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

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

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

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

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

Our values

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

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

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

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

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Increases / changes to capacity and demand . ii) leadership and capacity challenges iii) conflicting priorities iv) Inconsistency in application of pathways/ processes iv) Impact of COVID 19 measures - PPE, testing, social distancing, staff and patient risk assessments, availability of workforce. v) Impact of specialist commissioning review and resultant outcome for MVCC on staff retention and recruitment, impacting on effectiveness of the cancer team. vi) Increased risk to delivery of the ERF targets. More challenging delivery targets from 1st July (95% activity against a 19/20 baseline) – if the system does not meet these targets ERF monies will not be paid. vii) The Emergency Care Data Set (ECDS) for urgent and emergency care is being revised and Trusts will be expected to report against three new metrics from 1 November 2021 ('time to initial assessment', '12 hours in the department' and 'clinical ready to proceed')	i) Limited ability to respond to changes in capacity and demand impacting on service delivery - changes to referal patterns following COVID. Patients presenting later to GP's ii) Adverse impact on sustaining delivery of core standards iii) impact on patient safety, experience and outcomes iv) increased regulatory scrutiny v) reputation - Public confidence vi) Financial Impact if the Trust does not meet the ERF targets - ERF monies will not be paid. vii) Reputational risk if performance standards are not achieved	**Inherent Risk** (Without controls):	4	5	**20**	↑
		Residual/ Current Risk:	4	5	20	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Risk stratification of patients is ongoing, overseen by the Clinical Advisory Group. The group is chaired by a consultant. The Trust continues to have oversight of performance through three Delivery & Oversight Groups which meet monthly and focus on (1) Quality and Safety, (2) Performance and Transformation and (3) Finance and Workforce. In addition, a range of groups meet regularly to focus on specific aspects of performance and recovery. These groups take a targeted approached to review performance, identify risks and determine corrective action. These groups include a system-wide Cancer Board chaired by Trust's Chief Operating Officer, a weekly Gastroenterology Surveillance group and the weekly Executive Committee. A weekly access meeting takes place. Recovery plans are in place for all specialities and progress is reviewed on a weekly basis. A series of deep dives are planned for 2021/22.	We have a set of 'flat pack' Covid escalation plans ready for use if required and we have developed Covid policies and procedures. We have developed a recovery dashboard which is divisional and specialty based. FPPC receives and reviews our IPR, performance reports and deep dives at its meetings. It also reviews ED performance and configuration, progress in relation to the endoscopy review and demand and capacity modelling. In addition we have divisional delivery operational groups, divisional Board meetings and a fortnightly clinical transformation group. Performance Deep Dives - Stroke, July 2021, Sept 21	Recovery of our performance continues to be good and we are exceeding our plans. Performance against RTT and diagnostics is improving. -RTT and DMO1 deep dive to FPPC June 21. The number of patients waiting over 18 weeks is decreasing.		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1 Complexity of operation recovery in the context of COVID C2 National changes to guidance and policy requiring local response at short notice C3 Phase 3 capacity modeling to deliver national targets within financial model	A1 Define metrics to support monitoring of recovery A2 Capacity to support increased demand post COVID - endoscopy and other specialities - delivery against plans A3 Effectiveness of winter planning initiatives/ transformation with community A4 Optimisation and effective discharge	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

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

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

July 2021: New guidance has been issued requiring performance to be at 95% against 19/20 activity levels. This will be challenging to achieve, particularly with increasing Covid numbers and a predicted 4th Covid wave. If the system as a whole does not achieve the targets ERF monies will not be paid. Sept 21: Although challenging the Trust has so far performed well against these new standards. As we approach winter, competing pressures and an increase in Covid numbers and a potential decrease in available workforce could make this position harder to sustain'. October 2021: October 2021: Risk level reviewed at QSC and FPPC and recommended increasing the risk from 16 to 20; recognising the impact of the current operational performance/ challenges and continued challenges of activity, winter pressures, competing priorities, impact of staff sickness. FPPC recieved a deep dive and assurance on the Discharge Improvement Programme and Winter Planning - including internal and system wide actions/initiatives to support mitigation of the risk. Noting next months deep dive will focus on RTT recovery.

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

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

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

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

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

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	Gaps in Assurance:Where effectiveness of control is yet to be ascertained or negative assurance on control received.	Reasonable Assurance Rating: G, A, R	
C1. Inadequate links between service planning and workforce planning. C2. Lack of horizon scanning to allow early recognition of potential skills gaps. C3. National shortages of clinical professionals and failure to engage clinicians in the workforce planning process. C4. COVID/ Post covid challenge to existing workforce model - ability to maximise using staff flexibly	A1 the variation between current staffing arrangements and optimum workforce model is not yet quantified. A2 ability readily monitor capability, specialist skills and risk assessments to maximise using staff flexibly	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: (Actions under review with CPO)	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Ongoing implementation of the People Strategy to support staff recruitment and retention, in particular through the development of a strategic forum to link future organisational design requirements with job design and provision of necessary educational support.	C1, A1	Chief People Officer		Staff experience Group in place to consider exit interview data / undertaking workforce planning with services via the integrated business planning process will identify new ways of working and roles to support development / education board considers other development and training mechanisms to support R&R	
ii) Enhance areas of staff supply	C2	Chief People Officer		Continue to work with NHS Professionals on bank recruitment to support staffing shortfalls, plans have been agreed for 21-22 with clear targets in place throughout all staff-groups. / International recruitment continues to identify and recuit additional staff as needed	
iii) Work with divisional leadership on demand and capacity modelling, and establish workforce architecture/modelling approach and capability	C1, C2, A1	Chief People Officer		Workforce Planning gap identified in current establishment, has been addressed in the revised people team structure. Some work has been undertaken with the planning team around demand and capacity modelling but in it's infancy.	
iv) Improve the offer to staff around flexible working.	C4, A2	Chief People Officer		flexible working review being undertake in conjunction with establishment review to assess winter and summer plans and options appraisals.	
Summary Narrative:					

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

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

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

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
• Change in the national funding framework during COVID • Mid Year change in funding framework• Good financial management and governance not maintained • Allocation of resources via system mechanisms rather than based on activity volumes• Impact of revised operational targets (eg. P3 recovery / Winter & COVID Resilience) • Dilution of financial understanding and knowledge within divisional teams• New operational structures weakening traditional arrangements for strong financial control	• Significant increase in costs above funding levels • Financial balance not maintained • Failure to track expenditure causation • Unable to invest in service development • Challenge in tracking spend for regulatory and audit purposes • System funds allocated on differential basis• Spend committed recurrently in response to non recurrent circumstances• Breakdown of regular financial / business performance meetings• Weakening of traditional balance between - Finance / Performance & Quality	**Inherent Risk** (Without controls):	4	5	**20**	↓
		Residual/ Current Risk:	4	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**
• Regular Monthly financial reporting arrangements in place• COVID expenditure tracking and approval processes in place• Recruitment approval mechanisms in place• Financial appraisal and pre-emptive agreement of winter pressure and P3 programmes • Attendance at regular national, regional and ICS DOF briefing and engagement sessions • Suite of weekly internal Finance SMT meeting to track financial delivery and governance issues • Mth 1-6 and M7-12, internal budget frameworks in place • Strong framework of BI financial reporting tools deployed to track and monitor delivery • Weekly Demand & Capacity meetings to track P3 delivery achievement and associated PAM meetings to support accurate and comprehensive activity capture • MVCC Due Diligence meeting, plus Critical Infrastructure meeting • Implementation of Divisional Finance Boards to promote strong financial governance - Financial Planning 2021/22 & including ICS developments to FPPC in January 21.	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 review programme - Costing Assurance Audit and action plan to FPPC in June 2021			I&E delivery against financial plan Cash balances maintained within prescribed limits • Capital spend to be maintained within approved levels • Temporary staffing spend to be maintained within agreed threshold

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

Action Plan to Address Gaps (Actions under review by Lead Director)

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Launch and development of Finance Academy for all Budget holders	C1, A2	Director of Finance		Launched in May 2021	In progress
ii) Development of Finance Sustainablity Strategy in line with the NHS Financial Framework and monitoring delivery	C2, C5, A1, A3,	Director of Finance		H2 planning guidance and budgets , FPPC Sept / October 21	
iii) Continue to develop BI and support divisions / directorates using effectively	C1, C4	Director of Finance			
iv) Engagement with Divisions/ Directrates on delivery on financial savings from month 6	C5, A4, A5	Director of Finance / Direcotr of Improvement / MD's (Planned ad Unplanned)		H2 CIP Delivery plan to Sept / October 21 FPPC	
Summary Narrative:					
October 2021: Risk level reviewed at FPPC and recommended reducing from 16 to 12, taking in to account the current and forecast position including the reports on the H2 Planning Guidance and budget and H2 CIP delivery.					

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

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

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

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

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

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

Action Plan to Address Gaps

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

June 2021 ,following review, including structures and monitoring in place, further actions and oversight of the risks, and the FPP Committee discussions in May 21, the rating has reduced to 16. October 2021: FPPC discussed the risk rating and confirmed it remains a 16; taking into account the longer term position of access to capital .

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

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

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

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

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

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

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

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

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

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

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

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	Positive Assurance (Internal or External) Evidence that controls are effective.	Positive Assurance Review Date	Key Performance Metrix aligned to IPR
• ICP Partnership Board Building on the successful system working in response to the pandemic • ICS CEO bi-weekly meeting ICS Chairs' meeting • Joint projects such as Vascular Hub project with West Herts and PAH; ICS pathology procurement; Imaging Networks • ENH improvement methodology - 'here to improve' • Integrated discharge team • OD support for ICP development • ICP Development Director based at ENHT one day/week to support developing relationships - ENH ICP Directors' Group	Reports to Board and FPC Reports to ICS CEOs' Reports to Partnership Board Reports to ICP CPex and TDG Collaboration Report to Strategy Committee and Board Pathology Procurement report, Vascular Services report and monitoring via Stategy Committee and Board Population health data presented to FPPC in May 21			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	Gaps in Assurance:Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	Reasonable Assurance Rating: G, A, R	
C1. Partnership Board Scope for accelerated development of ICP and governance arrangements that support collaborative transformation at pace C2 Need to identify and release clinical leadership capacity to drive greater pan system understanding of population health and priorities for ICP improvement work C3. Need to influence and understand future Trust and ICP representation with ICS from Apr 22 - Identification of dedicated capacity to support provider collaboration C4 Maximising the implementation of an improvement model to build capability and capacity	A1. Availability of population health data to inform shared priorities for transformation and improvement A2. ICS PHM learning set commenced March 21 Trust COO representaton at the ICP Transformation and development group to enable integrated pathway redesign. A3. Assurance that ENHT voice fully represented by ICS in key discussions e.g. satellite radiotherapy. To be discussed at CEO level	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

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

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

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

July 21 - ICP bid submitted for Community Diagnostic Hub at QEII, with pilot in community; helping to build joint working with system partners
June 21 - MoU recommended for approval by statutory Boards. ICP developing refreshed strategy and developing plans for April 22 in conjunction with ICS development and transformation. Work underway to test alternatve models of collaboration. Agreed joint transformation project to develop enhanced services in the community to support reduction of acute LoS and alternatives to admission.

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

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

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

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

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

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

Action Plan to Address Gaps

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

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

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

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

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

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

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

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

Action Plan to Address Gaps

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

October 21: Routine deep dive review at Audit Committee October 2021, Discussion on the impact of the backlog of activity , current activity pressures and changes to pathways in the context of quailty and safety. Assurance given on the actions being taken. Also discussed Medical Director and Chief Nurse holding joint strategic session for their senior teams. This will include review of quality and safety priorities, maximising working together and supporting the divisions effectively and streamlining meeting structure where possible.

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

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

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

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

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
i)Trust People Strategy designed to offer mitigations to this risk. ii) All staff are expected to embody PIVOT values. iii)Trust policies such as Dignity and Respect Policy and Raising Concerns Policy provide route for staff to voice concerns. iv) Freedom to Speak up Guardian can support staff to make their concerns known, so that the organisation can respond to those concerns. v)Staff Experience Group and Divisional Forums provide space for constructive dialogue with staff to impove staff engagement/experience. vi) Education Board provides means to drive forward new approaches to education and development for all staff. New role of Head of Culture to commence in June 2021 Equality and Inclusion Committee from May 21	i) Staff surveys, including quarterly Pulse survey ii) Monitoring of trends via reports to Trust Board and accountability through scrutiny at Trust Board. iii)Monitoring of level of challenge through application of staff policies, for example from under-represented groups.			
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**		
C1. failure to review and update some staffing policies C2. Need to develop education approach to supporting staff in under-represented groups C3. Need senior leadership development programmes to support the service improvement and transformation agenda. C4. Maximising the support networks abilty to influence service and culture change C5. Maximining staff access to wellbeing offers	A1. Failure to achieve Integrated Performance Review targets is an indication of negative assurance where the targets are relevant to this risk. A2. Capacity of F2SUG and static reporting	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Embed compassionate leadership approach to organisational management.	C1,	**Chief People Officer**	Jul-21	leadership rhythms and compassionate leadership conversations being rolled out across the orgnaisation. 150 targetted to attend ICS sessions 145 confirmed. Additional programmes being identified as part of culture strategy for FPPC consideration in July 2021	in progress
ii) Develop improved education and training offer for all staff groups.	C2	Chief People Officer	Oct-21	Capability strategy developed to support all staff groups across the organisation. Now developing further the delivery of the roadmap	in progress

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

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

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

Strategic Aim: 1. Quality: 5. Sustainability:

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

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

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

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

Action Plan to Address Gaps

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Substantive recuitment into leadership structure and other vacancies	C1, A1	Director of Estates and Facilities	Aug-21	Recruitment of E&F Compliance and Deputy Director of E&F underway - October 21: Deputy Director of E&F and E&F Compliance Manager both now in post.	In progress

ii) Development of Estates Strategy in line with the Organisational strategy	C3, C2	Director of Estates and Facilities	TBC	Progress report to Strategy Committee in September 21.	In progress
iii) Space Utilisation review and implement governance of decision making	C7	Director of Estates and Facilities	Dec-21	Systems for the management of space being investigated and compared. Investment required to implement	In progress
iv) Ensure actions plans and monitoring in place to raise the areas of 'limited assurance' to 'reasonable assurance' - for H&S, Medical Gases, Ventilation and decontamination . Including HSE notices.	C3, C2	Director of Estates and Facilities			
v) Complete the PAM gap analysis	A3, C2, C6	Director of Estates and Facilities	Dec-21	Compliance manager recruited and will prioritise this audit.	In progress
vi) Review mechanisms of oversight of complaince across all sites to ensure effective	C1, C3, C5, A1	Director of Estates and Facilities			
vi)					
Summary Narrative:					

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

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

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

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

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	Positive Assurance (Internal or External) Evidence that controls are effective.	Positive Assurance Review Date	Key Performance Metrix aligned to IPR
- Programme Board governance in place for Strategic Review of the MVCC - Weekly ENHT, UCLH and NHSE Director level call in place and monthly Tripartite meeting in place to monitor delivery of the Strategic Review against plan - Fortnightly Due Diligence governance meeting in place (NHSE, UCLH, ENHT, HHT) - UCLH Transition Team in place at MVCC - ENHT MVCC Transfer Programme leadership (Programme Director) and governance (Steering Committee and Task & Finish) in place - Escalation reporting to Strategy Committee and Board - Clinical policies - Monthly ENHT, UCLH, NHSE Critical Infrastructure Review in place underpinned by action plans & risk register - MVCC Service Sustainability Forum (NHSE, ENHT, ENH CCG, HHT and UCLH) established to oversee monitoring of a monthly integrated sustainability dashboard to enable early identification of increasing service fragility	- Regular reports to Strategy Committee and the Board - Status reporting through ENHT Steering Committee - July 21 - Audit Committee Deep Dive	- Strategic review and recommendations from clinical advisory panel re MVCC, July 2019 - Positive Risk Review with Specialist Commissioners, December 2019 - Jan 20 NHSE approved the recommendation that UCLH is the preferred tertiary provider for MVCC (Jan 2020) subject to due diligence outcome. - NHSI/E Risk Review - significant assurance provided and decision to step down to BAU assurance monitoring. - Dec 2020 MVCC Review Programme Board - supported recommendation for full replacement and enhancement of current MVCC services on an acute site; shortlisted Watford (meets all essential criteria) and supported full options appraisal on the Watford site. - May 2021 Submission of Due Diligence reports from UCLH to NHSE. - June 2021 - East of England Clinical Senate review of proposals; informal feedback from review team has been positive - Sept 2021 - UCLH Expression of Interest submitted to DHSC, with support from ENH Trust Board, seeking route to capital as part of new hospitals programme		
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**		
	A1) Confirmation by NHSE of route to access capital for reprovision by UCH, and outcome of public consultation as required by UCH Board A2) Mitigation of financial impact of transfer on our Trust A3) Confirmation of UCH operational and corporate capacity to conclude DD to outcome and implement transition A4) Confirmation of ENHT operational and corporate capacity to implement transition	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

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

ii) Provide input and support as relevant to NHSE activities to access capital	A1	Director of Finance	Ongoing	- Input provided to capital paper shared with NHSE Finance colleagues - Input and support provided for UCLH Expression of Interest in capital as part of DHSC new hospitals programme	In progress
iii) Chief Executive briefing of regional team to support activities in relation to access capital	A1	CEO	Ongoing	- Briefing of Ann Radmore	In progress
iv) Support public consultation process through effective development and execution of ENHT communications and engagement plan	A1	Director of Finance	TBC	- Planning to start once timing of Public Consultation is clearer, dependent on capital assurance	Not yet started
v) Finalise assessment of ENHT stranded costs	A2	Director of Finance	May-21	- Initial Financial Impact Assessment of MVCC Transfer on ENHT has been developed; detailed analysis completed. To be refreshed as required over time	Complete
vi) Negotiate settlement with NHSE to address ENHT stranded costs	A2	Director of Finance	Jul-21	- Review of stranded costs agreed with NHSE mid June 2021	Complete
vii) Lead definition and execution of plans to reshape corporate departments to deliver target reductions in corporate overheads	A2	Director of Finance	Mar-22	- Meetings held in May at which Corporate Directors shared their plans	In progress
viii) Seek assurance from UCH of commitment to resourcing and plans at programme governance forums	A3	Programme Director – MVCC Transfer	May-21 Ongoing - dates to be realigned with earliest possible transfer of October 22	- Assurance sought from UCH re resourcing and commitment to delivery Due Diligence activities to revised plan - Initital discussions underway between ENHT and UCLH to discuss transition planning principles, approach and governance	Complete In progress
ix) Lead the programme-level development of transition and decoupling plans to identify corporate and divisional resources required to implement transition	A4	Programme Director – MVCC Transfer	Ongoing - dates to be realigned with earliest possible transfer of October 22	- Prior to confirmation from NHSE supporting work at risk, initial transfer and transition/de-coupling activities underway	In progress
Summary Narrative:					

May 21 - Due Diligence is due to complete at the end of May. Overall Strategic Review Programme milestones are under review, to be presented at May Programme Board, with an expected commitment to continue to target an April 22 transfer date.

June 21 - Strategic Review Programme Board in May presented a 'Plan A' timeline with Transfer date of April 22 and 'Plan B' timeline which would move the transfer date to July 22. Both dates are at risk due to critical dependency on route to capital, which remains unclear. UCLH Due Diligence reports with revenue and capital requests were submitted at end May 21 to NHSE for assurance process.
June 21 - Strategy Board - discussed MVCC Programme transfer update and noted the completion of the UCLH due diligence. Due to the level risk of a delay to the programme increasing the Committee increase the current risk score from 12 to 16. Work being undertaken to mitigate the risk was noted.

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

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

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

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

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

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Covid 19 outbreak/pandemic - impact of varients nationally and world wide - 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 vi) Likelihood of future surges / increase in covid numbers resulting in an increase in Covid numbers and hospitalisations, ventilated patients and a decrease in available workforce. v)Future Covid surges combined with a decrease in available workforce could have a negative impact on staff resilience	i) Risk of staff unable to attend work - due to self isolation or covid 19 positive. ii) Risk to patient safety as unable to provide safe staffing iii) There is a risk to the Trust's reputation if an outbreak was to occur/or criticism of our procedures. iii) Risk that some services are suspended for a period e.g. non urgent elective surgery, training iv) Risk of not meeting regulatory requirements v) Risk of financial impact if regulatory requirements are not achieved	**Inherent Risk** (Without controls):	5	4	**20**	
		Residual/ Current Risk:	5	3	10	
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Major incident Plan and Business continuity plans in place. Major Incident Command structure - Strategic, Tactical and Operational (Gold , silver, bronze) Command structures reviewed/adapted to ensure continued support to organisation / major incident Communication plan - internal and external Linked into and represented at Local and National resilience fourms/ communications/ conference calls Emergency Preparedness, Resilience and Response Committee - Chaired by Managing Director for Unplanned Care COVID Specialist Advisory Group with task and finish group structure reporting to it On call rotas - various Staff training programme - MI, loggist, Fit testing, skills refresh. Mortuary Capacity Plans IPC Policies and BAF Review and monitoring of O2 and ventialation Staff well being programme and deployment / reassignment processes - flexible (workforce triggers in place) Monitoring, review and recording of all national guidance and directives recieved re pandemic People and placed based risk assessments re COVID Social Distancing strategy Regional and Trust Local Indicators to suport decision making Flat packed pathways e.g. Ability to step up capacity esp in respiratory and critcal care pathways LFT testing and fast tracked PCR testing available for all staff Staff vaccine hub and vaccination programme Visitors Policies - including agreed triggers if changes required.	COVID dashboard Weekly Audits on environmental, IPC, H&S and social distancing Action Log/ Minutes from Strategic (GOLD), Tactical (Silver) and COVID SAG Trust Communications	Compliant with Emergency Planning standards 2020/21.	Report to QSC, June 2021	
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**		
C1.Possibility of insufficient staff available on all shifts who have passed their FFP3 Fit testing C2.Possibility of staff 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. C3.Possibility of Trust visitors coming back or being exposed to people who have come back from the affected regions and presenting at the Trust. C4.There is a risk that patients are not screened on admission as per questions based on PHE guidance	A1 BCP's for high risk areas / small specialitist services/ On going resilience to sustain responsiveness to national guidance which is updated daily (esp in small teams / single posts) A2 Continuity of supplies as position changes - responding to national guidance and alerts A3 Adequacy of Ventilation in clinical areas	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	

about recent travel. C5.There is a risk that Trust and agency/bank staff may be confused by various external sources of information about WN-CoV and IPC precautions to take C6. There is a risk people in the community with symptoms are directed to ED, when they should stay at home - due to unclear community guidance C7. Business continuity plans may need to include WN-CoV. C8. Updates to national advice daily as the position changes C9. Demand for assessment and beds exceeds sideroom and bed capacity Requested regent to enable patient and staff testing internally / capacity of CUH to support increased testing Impact of COVID surge 2 on capacity and staffing		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

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

June 2021, the Committee considered the assurances received including confirmation of maintaining compliance with the EPRR standards 2020/21 and supported reduce this risk from a 15 to 10. Noted triggers and action in place to 'unflat pack' surge plans and plan in place/underdevelopment for potential increase in children young people attendances/ admissions. July 2021: Command and C|ontrol structures reviewed - GOLD now meeting twice a week and reinstated SILVER from 21 July 2021. Workstreams, task and finish groups and surge plans - reviewed and stood up. October 2021: Review of operational triggers and strucutre to support escalation commenced (taking into account the winter pressures) .

East and North Hertfordshire NHS Trust

Agenda Item: 9

TRUST BOARD - PUBLIC SESSION – 3 NOVEMBER 2021

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: N/A		
Director: All Directors	**Presented by:** All Directors	**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	☒

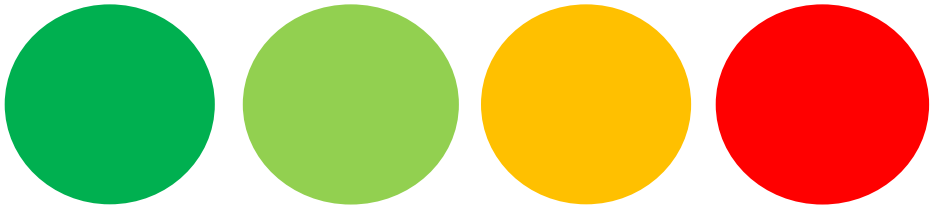
Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): Key challenges and mitigations under each domain are identified within the report.

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

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 06 | 2021-22



Data correct as at 22/10/2021

NHS Oversight Framework

East and North Hertfordshire NHS Trust

Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Overall	CQC rating	-	Dec-19	-	-	Requires improvement	
Caring	Written complaints - rate	Monthly	Sep-21	Local	1.9	0.0	
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-21 - Sep-21	National	0	2	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Sep-21	National	0	0	
Caring	Mixed-sex accommodation breaches	Monthly	Sep-21	National	0	no submission	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	Sep-21	Local	95.0%	97.7%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	Sep-21	Local	90.0%	81.5%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	Sep-21	Local	93.0%	66.7%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	Sep-21	Local	93.0%	94.3%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	Sep-21	Local	93.0%	96.2%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	Sep-21	Local	93.0%	100.0%	
Safe	Emergency c-section rate	Monthly	Sep-21	Local	15%	16%	
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-21	NHSI	52	33	
Safe	Clostridium difficile – infection rate	Monthly (12-month rolling)	Oct-20 - Sep-21	National	22.22	31.32	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Oct-20 - Sep-21	National	0.93	0.56	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly (12-month rolling)	Oct-20 - Sep-21	National	12.08	3.91	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Monthly (12-month rolling)	Oct-20 - Sep-21	National	26.09	18.45	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Jul-20 - Jun-21	National	100	80.8	
Effective	Summary Hospital-level Mortality Indicator	Monthly (12-month rolling)	Jun-20 - May-21	National	100	86.8	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	Mar-21 - Aug-21	National	16.94%	18.19%	

Finance

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Financial sustainability	Capital service capacity	Monthly	Aug-21	National	1	n/a	
Financial sustainability	Liquidity (days)	Monthly	Aug-21	National	1	n/a	
Financial efficiency	Income and expenditure (I&E) margin	Monthly	Aug-21	National	1	n/a	
Financial controls	Distance from financial plan	Monthly	Aug-21	National	1	n/a	
Financial controls	Agency spend	Monthly	Aug-21	National	1	n/a	

Operational performance

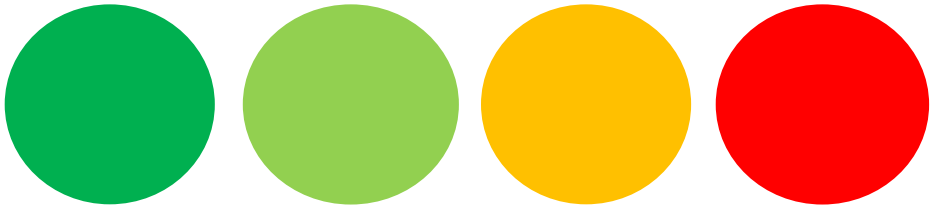
A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	Sep-21	National	95%	69.51%	
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	Sep-21	National	92%	59.43%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Aug-21	National	85%	86.10%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Aug-21	National	90%	85.00%	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	Aug-21	National	1%	37.01%	
The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who:							
Dementia assessment and referral	a. have a diagnosis of dementia or delirium or to whom case finding is applied	Monthly	-	National	95%	-	
	b. who, if identified as potentially having dementia or delirium, are appropriately assessed	Monthly	-	National	95%	-	
	c. where the outcome was positive or inconclusive, are referred on to specialist services	Monthly	-	National	95%	-	

Leadership and workforce

Organisational health	Staff sickness	Monthly	Sep-21	Local	3.8%	4.85%	
Organisational health	Staff turnover	Monthly	Sep-21	Local	12.0%	12.8%	
Organisational health	Proportion of temporary staff	Monthly	Sep-21	Local	-	14.3%	
Organisational health	NHS Staff Survey Recommend as a place to work	Annual	2019	National	63.3%	58.1%	
Organisational health	NHS Staff Survey Support and compassion	Annual	2019	National	20.9%	22.5%	
Organisational health	NHS Staff Survey Teamwork	Annual	2019	National	65.5%	66.2%	
Organisational health	NHS Staff Survey Inclusion	Annual	2019	National	87.8%	86.7%	
Organisational health	BME leadership ambition (WRES) re executive appointments	Annual	2019	National	7.4%	0.0%	

Quality & Safety

Month 06 | 2021-22



East and North Hertfordshire NHS Trust

Summary

Key Issues	Executive Response
Serious Incidents • 98% of incidents reported during Sep were low and no harm incidents (combined). • 6 cases were declared as serious incidents in September 2021. • SI cases were related to: - HSIB - 4 - HOCI Cluster (3) - 1 - Arterial line Cluster (2) - 1 **Infection Control** - MRSA - 0 - CDIff - 3 - Ecoli - 7 - MSSA - 1 - Klebsiella - 3 - Pseudomonas aerudinosa - 4 - CPOs - 0 - Hand Hygiene - 90.61%, increased from 89.3% in August. **Deteriorating Patients** • The trust continues to see a sustained improvement in hospital cardiac arrest rates • A key improvement priority is reliability of observations. **Sepsis screening** • Inpatient and ED sample size captured continues to improve. • Inpatient 6/6 sepsis bundle compliance decreased from 42% in July to 16% in September. • ED sepsis bundle has decreased from 37% in July to 36% in September. **Venous Thrombo-embolism** • VTE risk assessment remains a safety improvement priority. • Step one VTE risk assessment has reduced to 74% (below Trust target of 85%) and step two (within 48 hours of admission) has also decreased to 43% in September. **Complaints** • There were 71 complaints received in September. • Complaints acknowledged within 3 working days idereased to 86% but remains above the Trust target of 75%. • The final response to complaints decreased from 87% in August to 40% in September amd is below the Trust target of 80%. • 78 Complaints were also closed in September.	**Serious Incidents** • The improvement trajectory has partially been achieved by completion of cluster reviews and older serious incidents are completed by the end of September, with a concentrated effort to ensure improved timeliness investigations going forward through more collaborative ways of working in structured, responsive approaches such as round tables. • Round tables have been undertaken to learn from cluster of various ED incidents. Several ward areas where falls with harm have occurred and cluster of ward areas where harm has occurred due to recognition and management of the deteriorating patients. In total 20 incidents have been investigated and reports written. • Hospital onset COVID case reviews continue to be presented through SIRP and reports are in progress, with additional resource to support. Application of duty of candour remains a priority. **Infection Control** • The numbers in September have shown a sustained level of COVID patients, mostly in the twenties. • There has been 1 COVID-19 outbreak reported in September on Ashwell ward. There are a total of 5 patients and 1 student. The ongoing COVID outbreak on Ashwell ward is expected to end on the 5th October 2021, 28 days after the last known positive result, should no further positive patients or staff be identified. • The COVID outbreak on ward 9A North ended on the 24th September 2021. This involved 12 patients and 1 student. • There continues to be no hospital acquired MRSA bacteraemias detected. • Community cases COCA of E.coli remain high in September with 21 community cases being reported. The Trust has reported 7 healthcare associated cases for E.coli in the month of September. • There has been a decrease in the numbers of healthcare associated C.difficile infections in September with 3 HOHA cases being reported. • There has also been a sharp decrease in the numbers of healthcare associated MSSA infections with 1 HOHA case being reported in September. • IPC supported Estates colleagues with trail ventilation plans to improve ventilation in specific challenged areas. • SSI NOF (Fractured Neck of Femur) continues to be higher than the national benchmark, but the internal focus on quality and improvement measures remain. **Deteriorating patients** • Designing the launch of digital doctor escalations has been underway for a planned go live date in October 2021. • Sustained improvement in reliably of 4 hourly observations remains on a good trajectory. • Reliability of 1 hourly observations showing an improving trend . • Vital signs competency based model now in progress. **Sepsis** • The sepsis team continue to support Inpatient & ED teams with the timely recognition of sepsis. The team also support the team deliver sepsis treatment when capacity or skill mix challenges are present clinically. • Significant decline in IV abx and IV fluid administration along with urine output measurement blood cultures and lactate measurements contributing to 26% reduction on overall Sepsis 6. • ED Fluid balance monitoring remains a priority for improvement of overall sepsis 6 compliance; digital solutions are being designed through 'Keeping our patient safe' digital programme. • CCOT and Sepsis team are leading sepsis competency train the trainer model and shall track compliance both through ENH academy and Pathways to Excellence programme. **Venous Thrombo-embolism** • Interview for VTE Nurse/pharmacist lead post planned for early October. • EMPA pilot has identified some new risks that require mitigation for achieving good VTE risk assessment compliance, solutions in progress. **Complaints** • The processes between divisional and corporate teams are being reviewed to ensure final response to complaints remains a priority. • Recruitment of Patient experience and Complaints lead has now been completed.

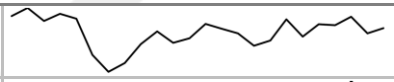
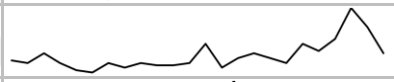
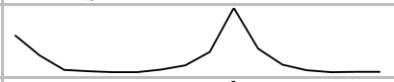
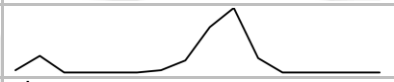
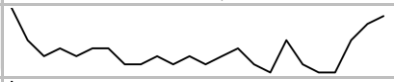
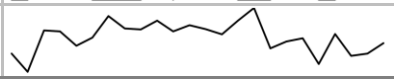
Safe Services

Summary

Please refer to the full Quality and Safety Report for M06 2021-22 for full details and narrative about these outliers and other Quality and Safety metrics.

Key

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

Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
Incidents	Total incidents reported	Sep-21	n/a	1,108	▲		Normal variation
	Serious incidents	Sep-21	5	8	▼		Special cause variation (2 point2 above upper control limit since Jul-21)
COVID	Number of deaths from COVID-19	Sep-21	n/a	20	n/a		
	Number of deaths from hospital-acquired COVID-19	Sep-21	n/a	2	n/a		
Infection Prevention and Control	Hospital-acquired MRSA	Sep-21	0	0	◀▶		Zero hospital-acquired MRSA since Dec-19
	Hospital-acquired c.difficile	Sep-21	n/a	3	▼		Normal variation
	Hospital-acquired e.coli	Sep-21	n/a	7	▲		Normal variation but increasing since May 21
	Hospital-acquired MSSA	Sep-21	n/a	1	◀▶		Special cause variation (1 point above upper control limit since Jul-21)
	Hospital-acquired klebsiella	Sep-21	n/a	3	▲		Normal variation
	Hospital-acquired pseudomonas aerudinosa	Sep-21	n/a	4	▲		Special cause variation (2 points above upper control limit since Aug-21)
	Hand hygiene audit score	Sep-21	80%	90.6%	▲		Normal variation

Safe Services

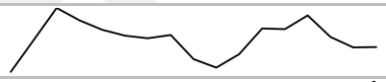
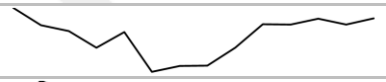
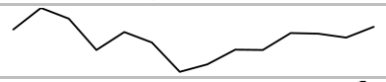
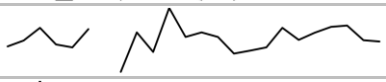
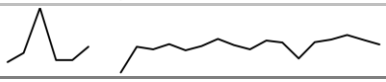
Summary

East and North Hertfordshire NHS Trust

Please refer to the full Quality and Safety Report for M06 2021-22 for full details and narrative about these outliers and other Quality and Safety metrics.

Key

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

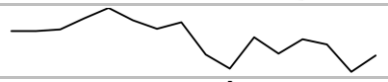
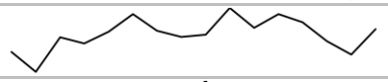
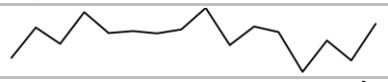
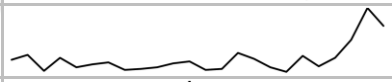
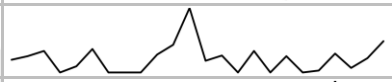
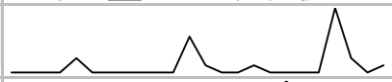
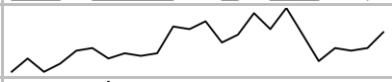
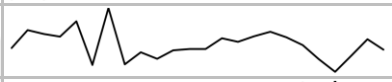
Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
Safer Staffing	Staff RAG rating	Sep-21	n/a	tbc	tbc		
	Overall fill rate	Sep-21	n/a	73.2%	▲		Normal variation
	Staff shortage incidents	Sep-21	n/a	36	▼		Normal variation
Safer Surgery	Checklist compliance	Sep-21	n/a	tbc	tbc		
	Serious incidents/never events related to invasive procedures	Sep-21	n/a	tbc	tbc		
Deteriorating Patients	Reliability of observations (4-hour)	Sep-21	n/a	72.5%	▼		Special cause variation (7 points above the mean)
	Reliability of observations (1-hour)	Sep-21	50	44.4%	▲		Normal variation
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Sep-21	95%	71.0%	▼		Special cause variation (7 points above the mean)
	Inpatients Sepsis Six bundle compliance	Sep-21	95%	15.9%	▼		Normal variation
	ED attendances receiving IVABs within 1-hour of red flag	Sep-21	95%	69.9%	▼		Normal variation
	ED attendance Sepsis Six bundle compliance	Sep-21	95%	31.7%	▼		Normal variation

Summary

Please refer to the full Quality and Safety Report for M06 2021-22 for full details and narrative about these outliers and other Quality and Safety metrics.

Key

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

Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
VTE	VTE risk assessment stage 1 completed	Sep-21	95%	74.4%	▼		Normal variation
	VTE risk assessment for stage 2, 3 and / or 4	Sep-21	95%	42.6%	▼		Special cause variation (1 point below lowe control limit - Sep-21)
	Correct low molecular weight heparin prescribed and documented administration	Sep-21	95%	96.6%	▲		Normal variation
	TED stockings correctly prescribed and documentation of fitted	Sep-21	95%	55.1%	▼		Normal variation
HATs	Number of HAT RCAs in progress (rolling 24 mths)	Sep-21	n/a	58	▼		Special cause variation (2 point above upper control limit since Aug-21)
	Number of HAT RCAs completed	Sep-21	n/a	35	◀▶		Normal variation
	HATs confirmed potentially preventable	Sep-21	n/a	1	◀▶		Normal variation
PU	Pressure ulcers All category ≥2	Sep-21	n/a	20	▲		Normal variation
Patient Falls	Rate of patient falls per 1,000 overnight stays	Sep-21	n/a	3.98	▼		Normal variation
	Proportion of patient falls resulting in serious harm	Sep-21	n/a	1.7%	▲		Normal variation

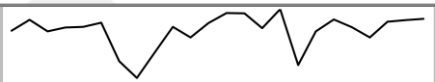
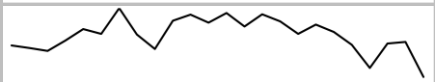
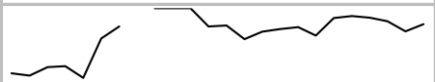
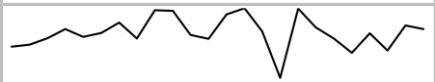
East and North Hertfordshire NHS Trust

Summary

Please refer to the full Quality and Safety Report for M05 2021-22 for full details and narrative about these outliers and other Quality and Safety metrics.

Key

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

Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
Friends and Family Test	Inpatient FFT Positive recommendations	Sep-21	93%	97.7%	▲		Normal variation
	A&E FFT Positive recommendations	Sep-21	93%	81.5%	▼		Special cause variation (1 point below lower control limit Sep-21)
	Maternity FFT - Antenatal Positive recommendations	Sep-21	93%	66.7%	▼		Normal variation
	Maternity FFT - Birth Positive recommendations	Sep-21	93%	94.3%	▼		Normal variation
	Maternity FFT - Postnatal Positive recommendations	Sep-21	93%	96.2%	▲		Normal variation
	Maternity FFT - Community Positive recommendations	Sep-21	93%	100.0%	◀▶		Normal variation
	Outpatients FFT Positive recommendations	Sep-21	95%	96.8%	▼		Normal variation
Dementia Referral and Assessment	Proportion who have a diagnosis of dementia or delirium or to whom case finding is applied	Sep-21	tbc	tbc	tbc		Under review
	Proportion who, if identified as potentially having dementia or delirium, are appropriately assessed	Sep-21	tbc	tbc	tbc		Under review
	Proportion where the outcome was positive or inconclusive, are referred on to specialist services	Sep-21	tbc	tbc	tbc		Under review

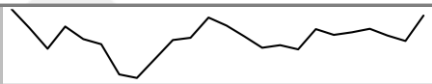
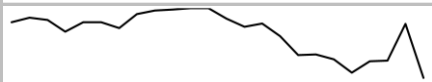
East and North Hertfordshire NHS Trust

Summary

Please refer to the full Quality and Safety Report for M05 2021-22 for full details and narrative about these outliers and other Quality and Safety metrics.

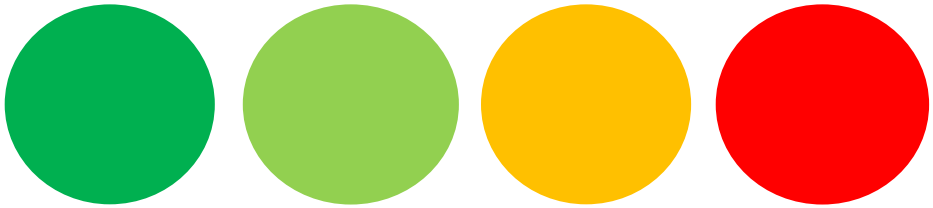
Key

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

Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
PALS	Number of PALS referrals	Sep-21	n/a	366	▲		Under review
Complaints	Number of written complaints received in month	Sep-21	n/a	71	▼		Normal variation
	Proportion of complaints acknowledged within 3 working days	Sep-21	75%	86%	▼		Special cause variation (2 points below lower control limit Jul 21 & Sep-21)
	Proportion of complaints responded to within agreed timeframe	Sep-21	80%	40%	▼		Special cause variation (5 points below lower control limit since Apr-21)

Effective Services

Month 06 | 2021-22



Key Issues

Crude Mortality
- The in-month crude mortality rate decreased from 14.14 deaths per 1,000 admissions in August, to 12.48 in September.
- The rolling 12-months crude mortality rate has increased to 14.23 deaths per 1,000 admissions in the 12 months to September, and is lower than the most recently available national rate of 14.81 deaths per 1,000 admissions (Jul-20 to Jun-21).

Hospital-Standardised Mortality Ratio
- The in-month HSMR has decreased from 86.67 in May to 81.27 in June.
- The rolling 12-months HSMR has decreased from 80.98 to 80.79 n the 12 months to June.
- The Trust remains within 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 increased slightly from 86.36 to 86.78.
- This Trust remains in the 'lower than expected, Band 3' category.

Re-admissions
- The re-admission rate for 12 months to June has decreased to 7.5% from 7.6%.

COVID-19
- To date CHKS analysis of our COVID-19 mortality has shown the Trust to be centrally placed in comparison to national and our PMO peer group.
- Probable/definite hospital acquired COVID-19 cases which sadly resulted in a death where COVID-19 was on part I of the death certificate have now been reviewed and passed to the SI Panel for consideration. To date over half have been discussed by Panel and declared SIs.
- 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 patients who died on re-admission within 28 days; (2) Deaths in the Community within 28 days of discharge. At June 2021 Mortality Surveillance Committee, it was agreed clinical thematic reviews should be undertaken of those who had died within 5 days of re-admission/ discharge. These reviews have been completed and the outputs discussed at the next Mortality Surveillance Committee. 3 deaths on readmission are to be further considered as ACONs and 1 death in the community is to be further reviewed by the Elderly Care team.

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.
- Work to integrate our mortality review process into the new Datix iCloud platform, when this is implemented into the Trust, continues.c

Executive Response

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

Executive Response (continued)

Crude Mortality (continued)
- This measure is available the day after the month end. It is the factor with the most significant impact on HSMR.
- 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 a 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 12month crude mortality rate was consistently better than the national average. While the COVID-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below or in line with the national average.

Hospital Standardised Mortality Ratio (HSMR)
- Our current HSMR of 80.79 (rolling 12 months to June 2021) positions us in the best performing quartile of Trusts nationally (18/123 trusts). We remain focussed on driving further improvement.
- The NHFD advised that we are a 3SD outlier for #NOF mortality for the Jan-Dec 2020 year. A detailed review together with remedial action plan has been approved and submitted to the Q&S Committee. Progress will be monitored by the Mortality Surveillance Committee.
- The significant changes in overall admissions and the change in case mix during the pandemic have made interpretation of this data challenging but the Trust's position will continue to be monitored.

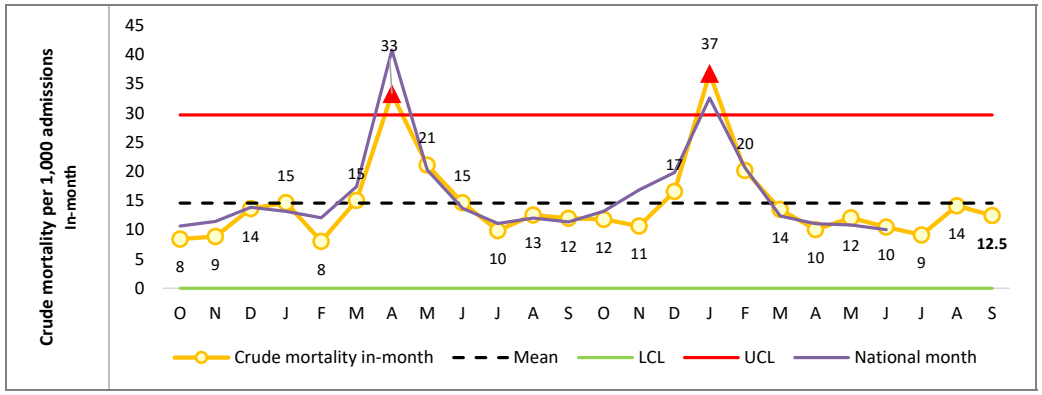
Summary Hospital-level Mortality Indicator (SHMI)
- Following significant improvements in SHMI, there has now been a sustained period of stability. The latest figure of 86.78 (12 months to May 2021) sees the Trust positioned within the 'lower than expected' band 3 category. Our position relative to our national peers currently stands at 13th out of all acute non-specialist trusts (123).
- COVID-19 activity continues to be excluded from the SHMI by NHS Digital.
- The fact that SHMI includes deaths within 30 days of discharge, and the Trust has remained well placed in comparison to the national picture, provides some assurance that our response to COVID-19 has not generally resulted in a disproportionate increase in deaths within 30 days of discharge.

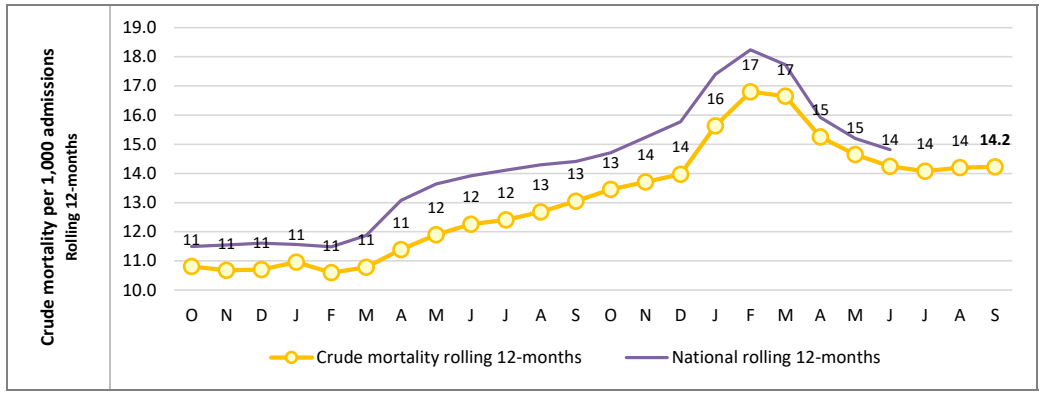
Re-admissions
- The Trust's re-admission rate has generally been consistent with the national performance. Significant dips in readmissions were seen in March and October 2020 while July to September saw the Trust's rate rise slightly above the national picture. Recent months have seen performance improve and stabilise, with the Trust tracking just below the national average.

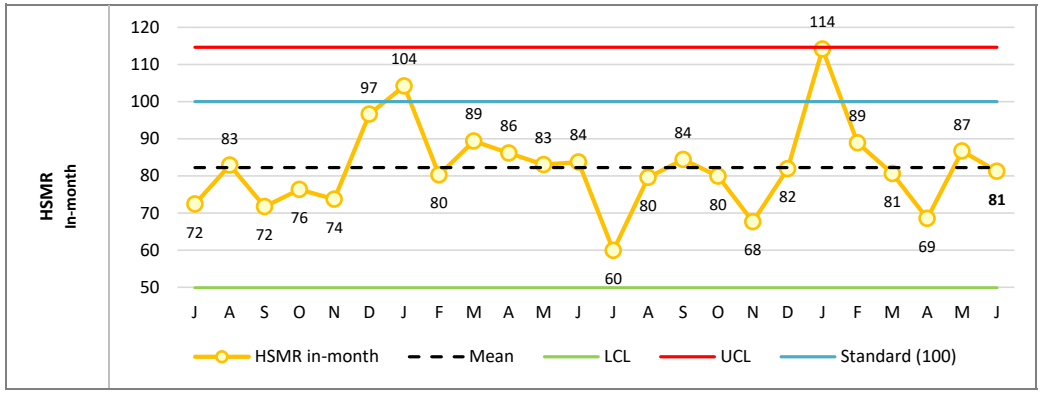
Learning from Deaths
- In addition to the outcomesof cases escalated to specialties being considered by the Mortality Surveillance Committee, the quarterly Learning from Deaths report includes a summary of key themes emerging from these cases. This detail is shared with all Trust Specialties and with interested working groups such as Deteriorating Patient, End of Life and Seven Day Services Steering Group.
- In tandem with the proposed move to Datix iCloud and full rollout of the Medical Examiner function a general review of our mortality review and learning from deaths processes is taking place. More news will follow.

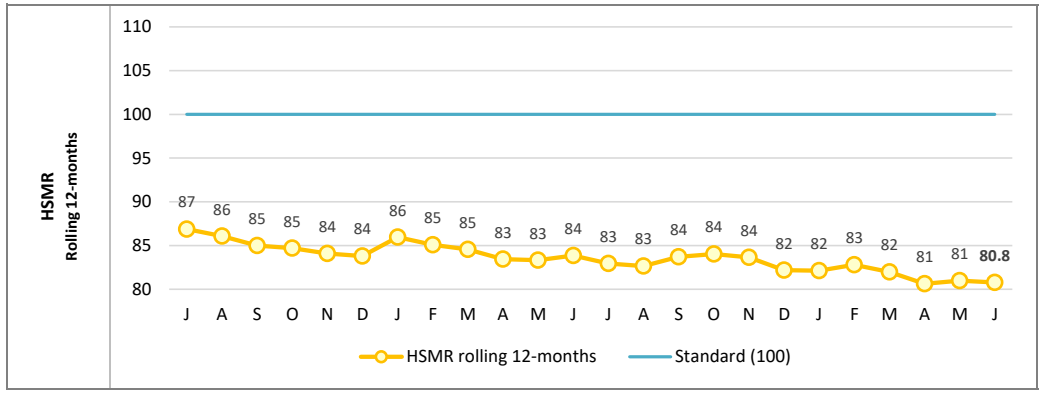
Mount Vernon
- The secession of MVCC as part of the Trust, will effect both our HSMR and SHMI. In addition to reporting the current situation, in preparation for the split we will shortly begin to report these metrics showing the anticipated effect of the loss of MVCC.

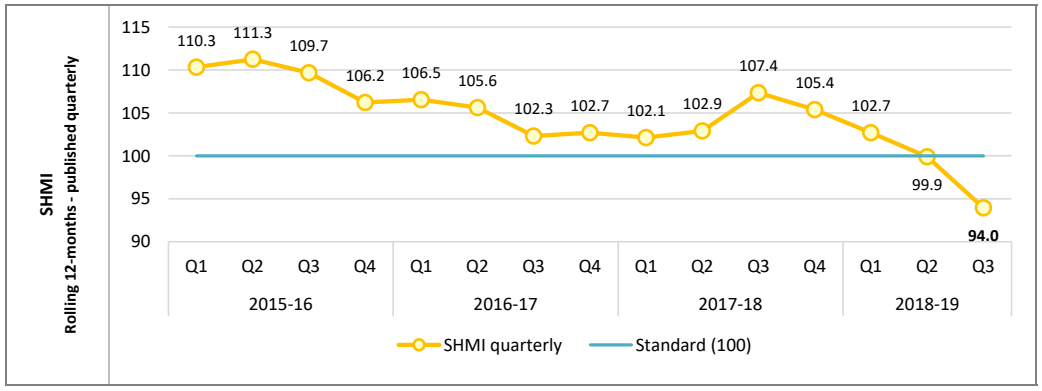
Specialist Palliative Care
- This data refers solely to patients under the care/review of the Palliative Care Team (PCT). Other data is available for deaths that are not known to the PCT. However, it resides in an access database and we are currently working through some data quality issues.

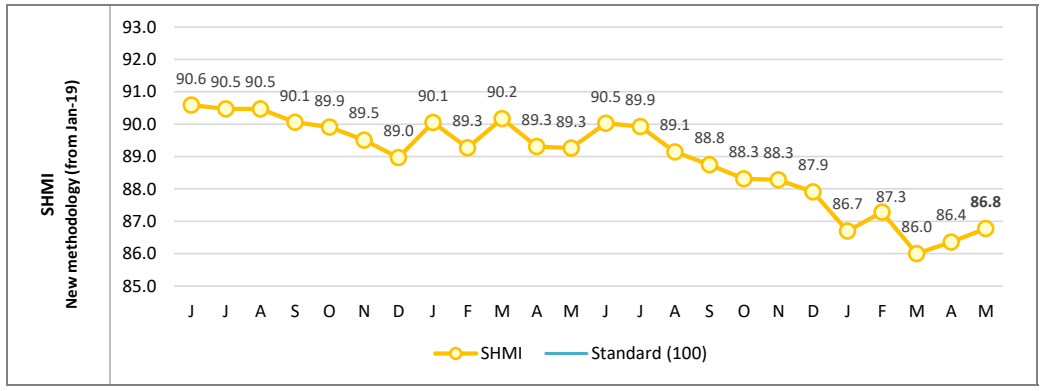

Crude mortality per 1,000 admissions
In-month
O N D J F M A M J J A S O N D J F M A M J J A S
8 9 14 15 8 15 33 21 15 10 13 12 12 11 17 37 20 14 10 12 10 9 14 12.5
Crude mortality in-month
Mean
LCL
UCL
National month


Crude mortality per 1,000 admissions
Rolling 12-months
O N D J F M A M J J A S O N D J F M A M J J A S
11 11 11 11 11 11 11 12 12 13 13 14 14 16 17 17 15 15 14 14 14 14.2
Crude mortality rolling 12-months
National rolling 12-months


HSMR
In-month
J A S O N D J F M A M J J A S O N D J F M A M J
72 83 72 76 74 97 104 80 89 86 83 84 60 80 84 80 68 82 114 89 81 69 87 81
HSMR in-month
Mean
LCL
UCL
Standard (100)

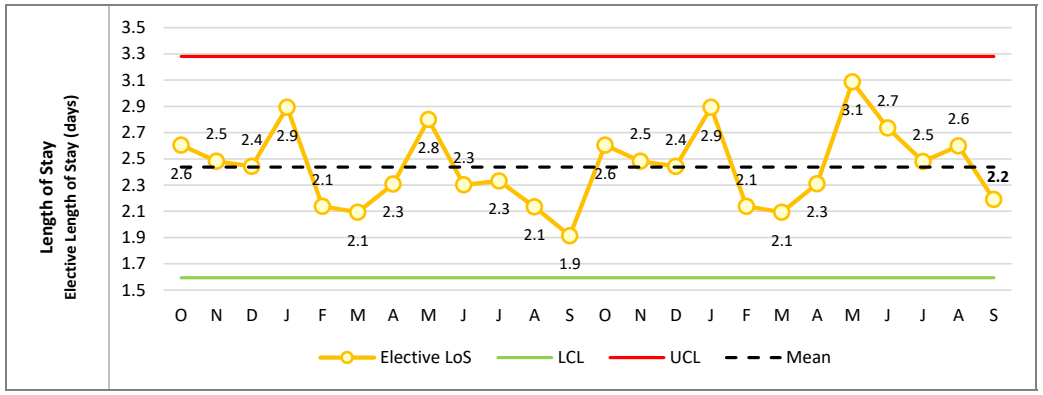

HSMR
Rolling 12-months
J A S O N D J F M A M J J A S O N D J F M A M J
87 86 85 85 84 84 86 85 85 83 83 84 83 83 84 84 84 82 82 83 82 81 81 80.8
HSMR rolling 12-months
Standard (100)

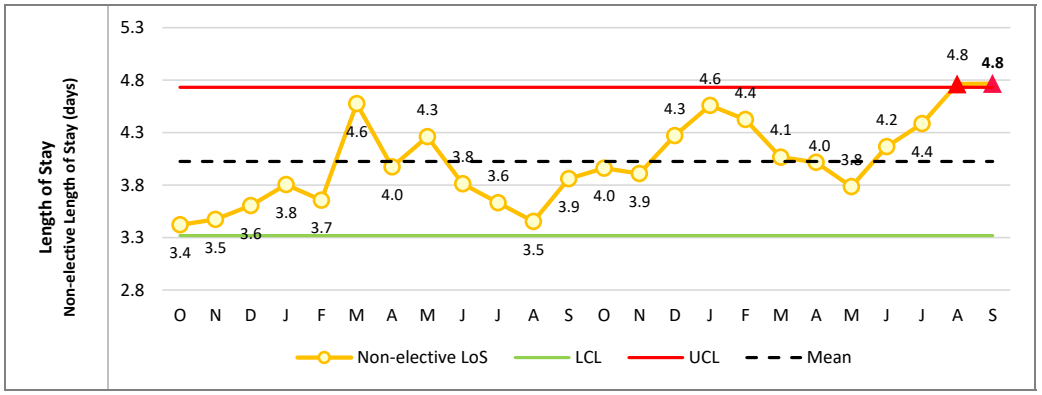

SHMI
Rolling 12-months - published quarterly
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2015-16
2016-17
2017-18
2018-19
110.3 111.3 109.7 106.2 106.5 105.6 102.3 102.7 102.1 102.9 107.4 105.4 102.7 99.9 94.0
SHMI quarterly
Standard (100)

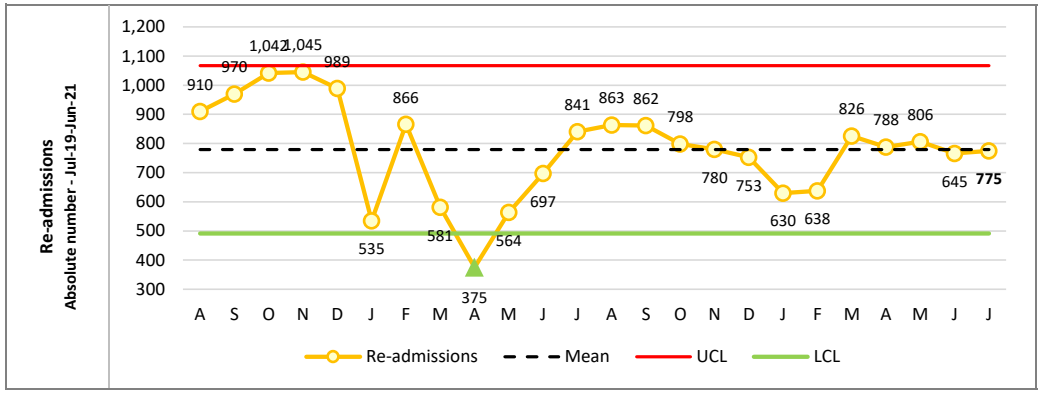

SHMI
New methodology (from Jan-19)
J J A S O N D J F M A M J J A S O N D J F M A M
90.6 90.5 90.5 90.1 89.9 89.5 89.0 90.1 89.3 90.2 89.3 89.3 90.5 89.9 89.1 88.8 88.3 88.3 87.9 86.7 87.3 86.0 86.4 86.8
SHMI
Standard (100)

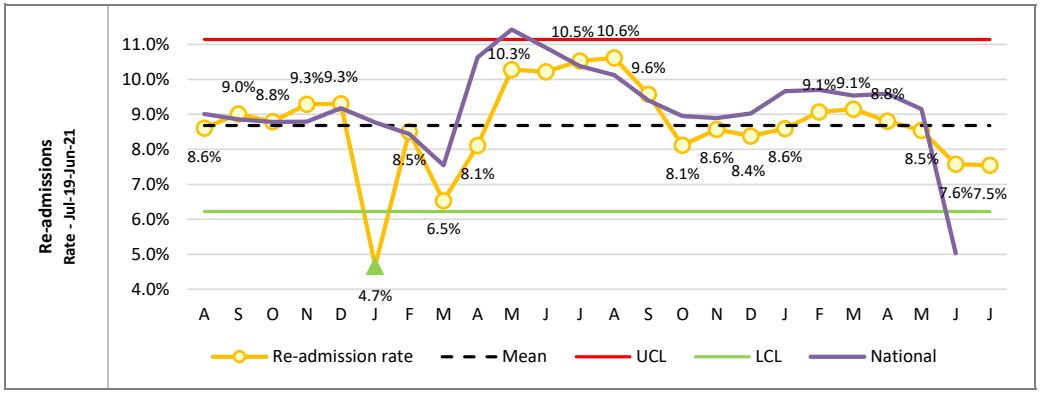
Effective Services

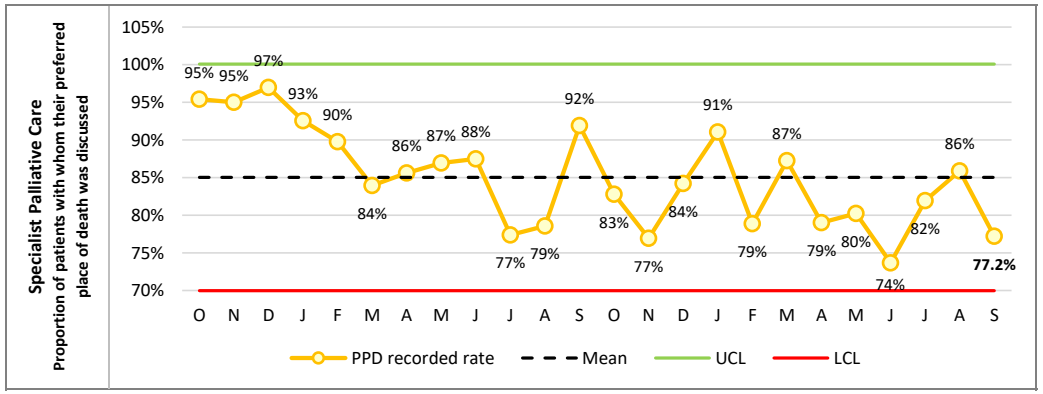
East and North Hertfordshire NHS Trust

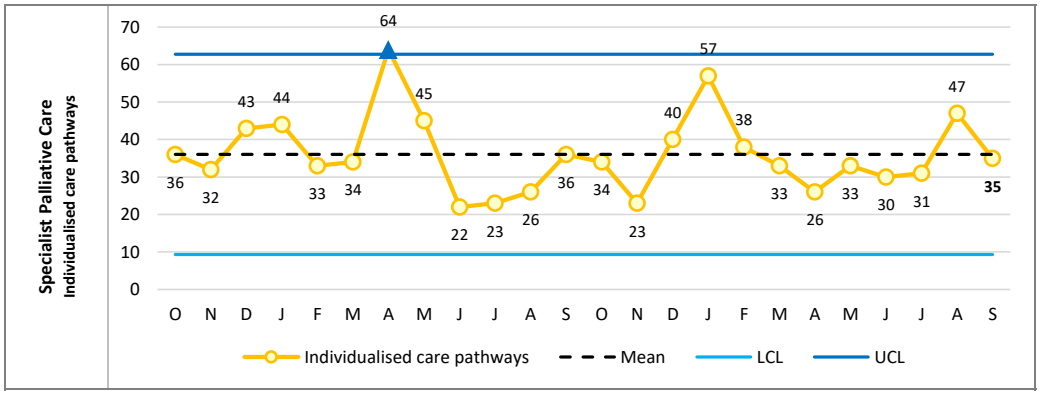






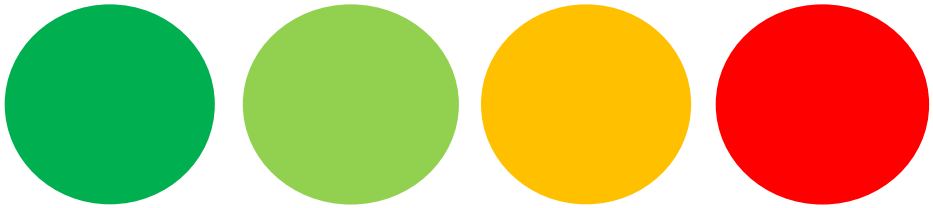






Responsive Services

Month 06 | 2021-22



Key Issues

A&E
- Performance for the month of September was 69.51%.
- There were zero 12-hour trolley waits reported in September.

Cancer Waiting Times
- The Trust achieved 6 out of the 8 national targets for Cancer performance in August.
- The Trust 62-day performance for August was 86.10%.
- There were 5 pathways over 104 days for the 62-day standard and 1 pathway over 104 days for 62-day screening. Longest wait is 6.5 days for 62-day standard.
- Good progress continues on the specialty cancer action plans, all plans being reviewed and updated weekly.
- Robust weekly cancer PTL management is in place.

RTT
- Incomplete performance for September was 59.43% This is a decrease from the 61.55% reported in August.
- The August backlog was 22,228, an increase of 1273 from 20,955 in August.
- There were 3,259 52-week breaches reported in the September incomplete position, an increase of 815 from the 2,095 reported in July.
- There were 65 patients waiting over 104 weeks: in September. The longest week wait currently is at 131 weeks.

Diagnostics
- DM01 performance for September was 37.01%, against the national standard of 1% and the August position of 37.44%.
- Latest available National performance (August) was 27.12%.

Stroke
- Stroke performance for September is 29.7% - reason for high number of breaches (45), low number of reported stroke in discharging month and the impact of the issues within ED.
- Thrombolysis performance is at 9.2% in September.
- Door-to-needle declined to 16.7% for September.
- CT 1-hour to scanning 49.2% below the 50% target.

Executive Response

A&E
- 4-hour standard and other professional standards have again deteriorated in month. This is due to continued high demand which has seen a substantial increase in attendances and high acuity. ED total occupancy continues to be of significant concern due to inability to social distance, poor patient visibility and potential safety concerns. Operational and senior medical and nursing support continues.
- Redirection and streaming pathways continue to evolve and develop. The ED Practice Development Nurse continues to provide ongoing training to increase the skills, knowledge, and confidence of the streaming nurses.
- Time to initial assessment has deteriorated. This is a reflection on the increase of daily attendances and high acuity presentations at the fornt door.
- The conversion to admission remained consistent with previous months. This is due to a combination of factors, improvement of flow to medical SDEC, long length of wait in ED which results in discharge from ED as apposed to being moved to assessment, lack of CDU capacity and lack of red SDEC space.
- The team continue to work hard to prevent any 12-hour breaches and monitor long waits, this remains a real challenge.
- The timing of NHS111 pre bookable slots continue to be reviewed and have been adjusted to reflect demand patterns. The early feedback suggests this is a positive change and will be formally reviewed during October.
- Ambulant Yellow ED (Majors 5) has remained open 24/7 to support continual demand on emergency services and to enable the segregation of patients with high Covid-19 risks, this has been recognised as gold standard by NHSE/I. However, it continues to be challenging to keep all areas of ED open due to staffing levels and sickness, which impacts on overall cubicle capacity to support timely ambulance offloads during periods of high demand. Continued efforts are made both within ED and by other colleagues such as the staffing matron , to ensure ED staffing is safe to mitigate any staffing gaps.
- Ambulance handover performance has stabilised however there are still improvements to be made within this area. The teams are working hard in conjunction with HALO to improve this position. The sucessful roll out of SIREN (ambulance software) will now support early identification of inbound patient needs . The team are now working towards the implementation of early planning of handover ahead of the patient's arrival. This will support the next phase roll out for SDEC patients diverting without the requirement to attend via the ED. Cohorting as an option is considered during peak times as well as effective communication with tactical leads to agree recovery plans.
- In month the average time in department for both admitted and non-admitted increased. Non admitted increased by approximately 20 minutes but admitted increased by almost 45 minutes. The site continues to push for more timely discharges, however this still remains a key factor in delays, along with delays in social discharges.

Executive Response (continued)

Cancer Performance (August)
- In August 21, the Trust achieved 6 of the 8 national targets and 1 out of 3 -28-day FDS standards for Cancer performance: 2ww GP Referrals, 2ww Breast Symptoms, 31-day First Treatment, 31-day Subsequent for Radiotherapy and Chemotherapy, 2ww FDS and 62-day urgent referral to treatment.
- 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 2021 the Trust performance was 98.6%.
- In August 2021, the Trust wide average days wait for first appointment is at 10 days and the majority of patients were seen between 8 and 12 days.
- The Trust has consistently delivered against the Breast Symptomatic national standard which requires 93% of patients referred to have attended the 1st Outpatient appointment within 14 days. For August 2021, the Trust performance was 97.8%.
- The Trust has consistently delivered the 31-day second or subsequent treatment for Radiotherapy and Chemotherapy but not for the subsequent Surgery. For August 2021 the Trust Chemotherapy performance was 99.5%, the Trust Radiotherapy performance was 98.7% and the Trust subsequent Surgery performance was 86.7%.
- The Trust performance for 31-day to first definitive treatment was 96.1%. The standard requires 96% of patients to receive treatment within 31 days of diagnosis.
- In August 2021, the Trust performance for the Faster Diagnosis is 72.7% for the 2ww patients, 78.9% for Breast Symptomatic and 50.0% for screening patients.
- Reported 62-day performance for August 2021 was pre-sharing 79.1% and post-sharing 86.5%.
- Cancer performance is available one month in arrears.

RTT
- 12,218 additional patients were seen in clinic compared to 2019/20 in September.
- Patient Tracking list:
  - Overall number of patients waiting increased in September.
  - The number of patients over 52 weeks has also increased.
  - The number of patients waiting over 104 weeks has increased by 8.
    - Reduction from 18to 19 in Orthopaedic patients.
    - Reduction from 24 to 30 in Pain patients.
- PTL management continues, reviewing and managing patients on our treatment lists.
- Validation plan in place and continues for waiting lists.
- Treatment priority given to patients (classified under the Royal College of Surgeons Guidelines (P1 – P6)), then long waiters taking into consideration of patient's needs, such as Learning Disabilities. 97.4% of admitted patients are risk stratified against the Royal College guidelines.
- 17 theatres are operational on the Lister site, use of the private sector continues.
- Recovery trajectories are being developed to support planning and mapping of capacity – Orthopaedics, Pain, Oral, have been completed, Gastroenterology underway.

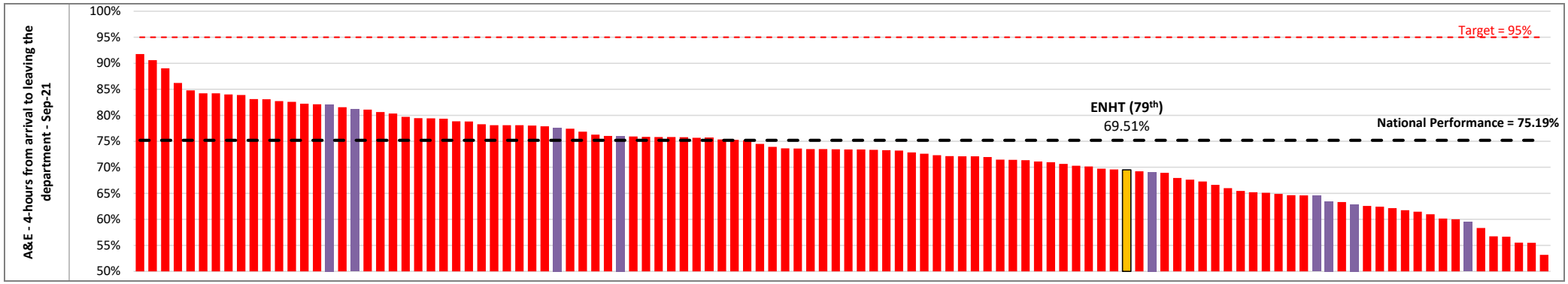
Diagnostics
- CT scanner replacement continues, impacting CT capacity, particularly for Cardiac CT, additional van capacity in place.
- Imaging demand continues to increase, highest referral rate in 18 months.
- Additional Endoscopy capacity in place to support driving down 6 and 13 week waits.
- In September there were no services that were DM01 compliant. Neurophysiology had no patients waiting above 13 weeks.
- There is an increase in the number of patients waiting for DEXA scans and CT Scans above 13 weeks this is a result of capacity issues. Dexa scans waiting over 13 weeks has decreased.
- Patients waiting have received a D code to ensure they are prioritised in order of clinical need.
- Diagnostics relating to cancer continued to improve in September.

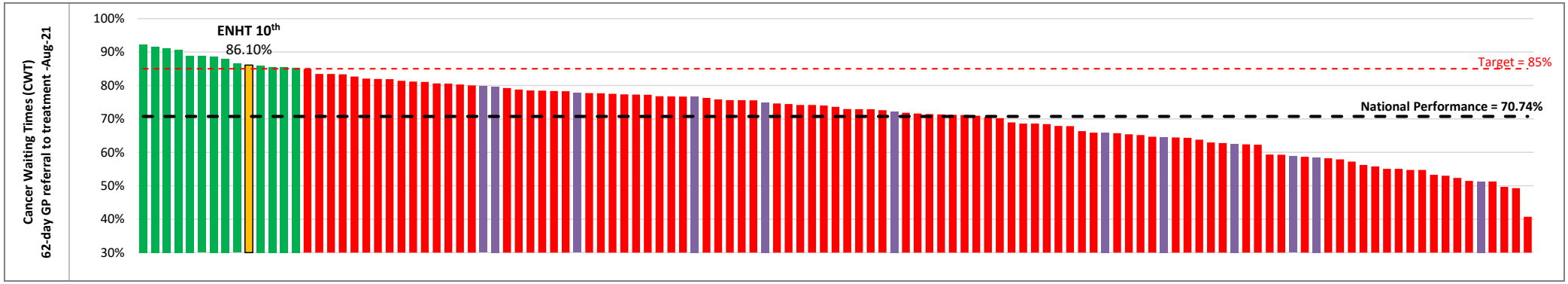
Stroke
- 4-hour performance, against the 63% target, for September was 29.7 %.
- Breakdown of breaches within working establishment. In-hour breaches: 38% / Out of Hour 62% - Out of hours is only provided by Stroke CNS and no Stroke specialism medical workforce and only Tele-Medicine providing support for Thrombolysis/Thrombectomy pathways.
- Concerns are ongoing with the requirements of Stroke beds needing to be used for Medical patients to support Trust position and to ensure safety. This reduces the available capacity for Stroke treatment and adherence to 4hr performance, impacting available bed capacity, which resulted in 27% of the overall breach reasons.
- Concerns with relation to the ED demand within the Month. This resulted in an impact of 16 Pathways/5 Late referrals (47%) of overall breaches due to late referrals to Stroke services - due to the impact of Demand within ED and Ambulance offload delays.
- Challenging/Complex cases: Of the 45 breaches, 7 (16%) were due to the demand on services and limited resource for support out of hours within the Stroke Medical workforce and overall demand on Stroke services and delays within ED pathway.
- SNNAP rating performance reduction. Main contributing factors are OT/PT non-compliance of establishment in-line with National Specification. A business case has been provided for approval to support levels to be compliant and therefore provide the necessary delivery of care in accordance with the SNNAP requirement.
- Door to Needle performance within 1hr is 16.7%. This is due to delays within the pathway due to impact on demand within ED
- 3 patient transfered to Charling Cross as per Thrombectomy pathway, with delays to being on a Stroke unit within 4hrs from ENHT arrival and arrival to Charling Cross within 4 hrs. - due to travel time and delays within Ambulances to support transfers.

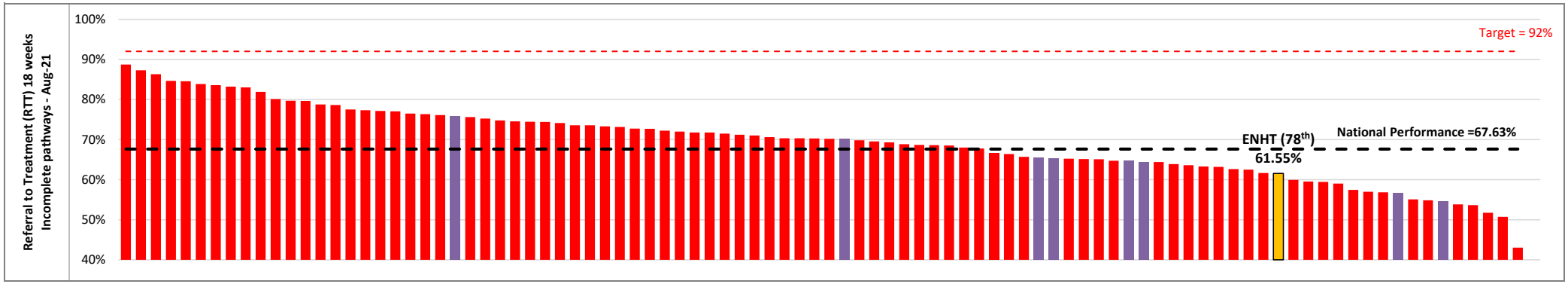
Responsive Services

Trust performance against all Trusts nationally

East and North Hertfordshire NHS Trust



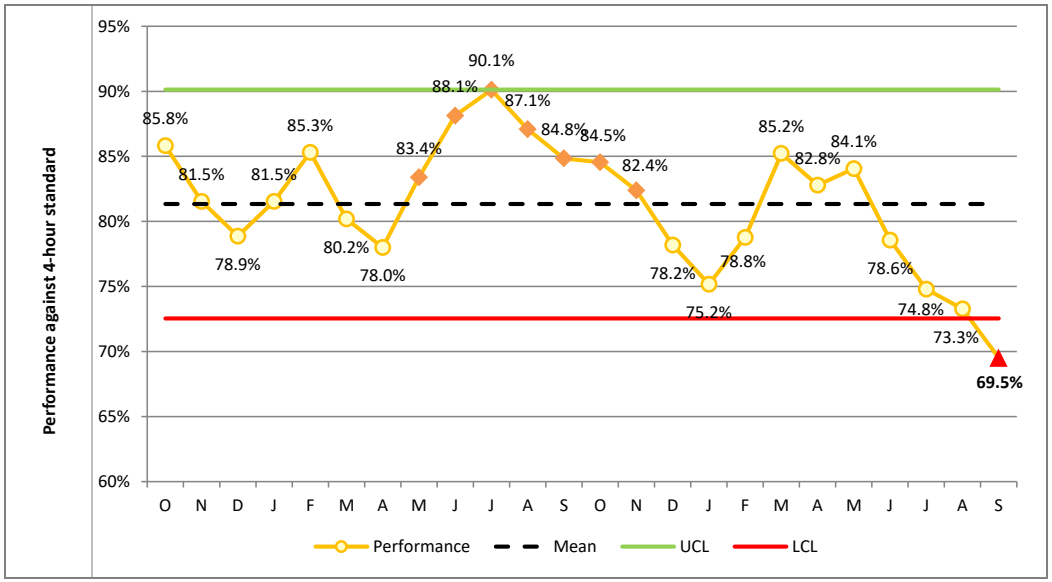




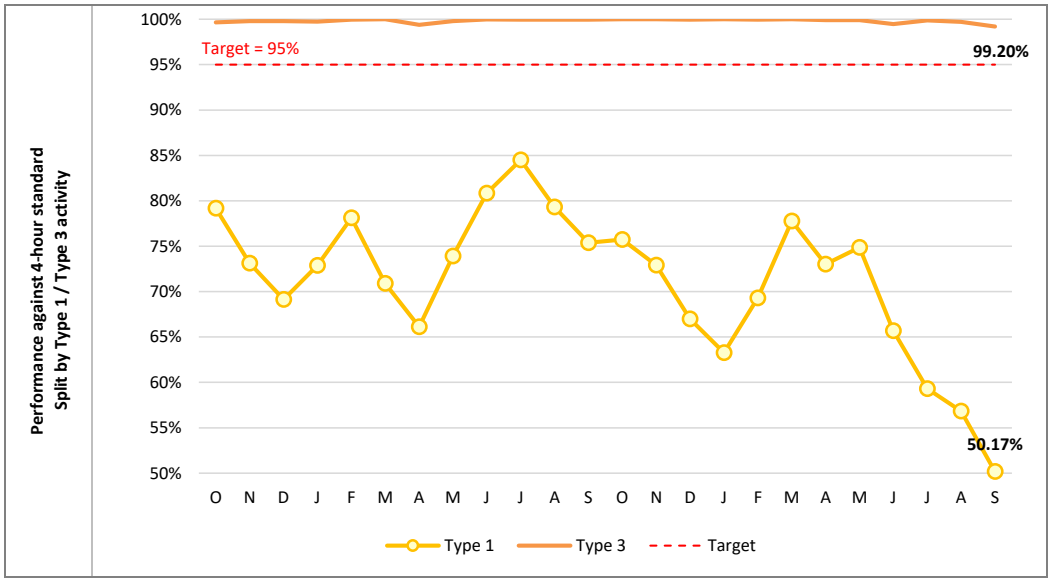
Responsive Services

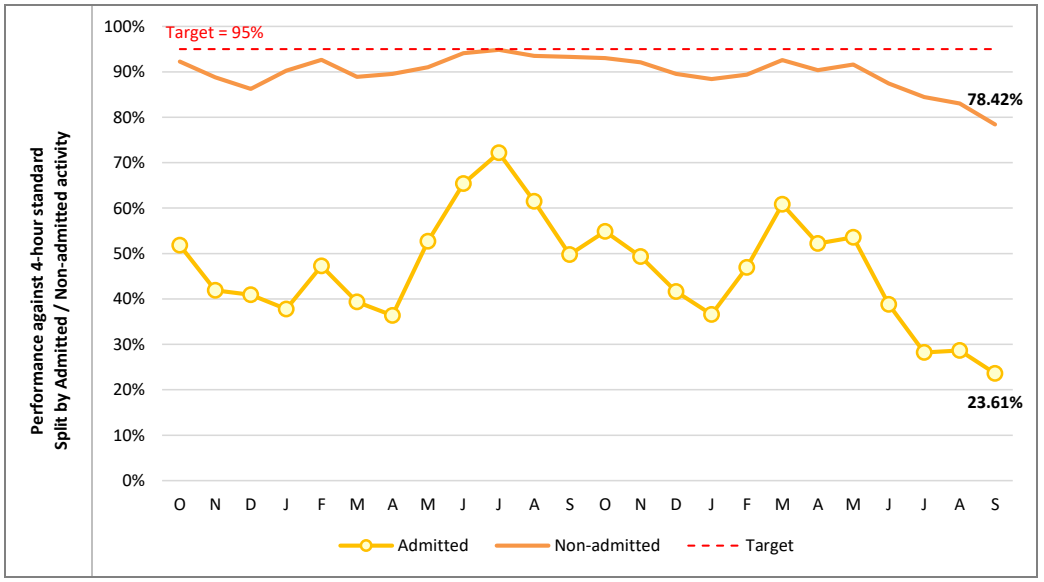
Emergency Department Performance

East and North Hertfordshire NHS Trust



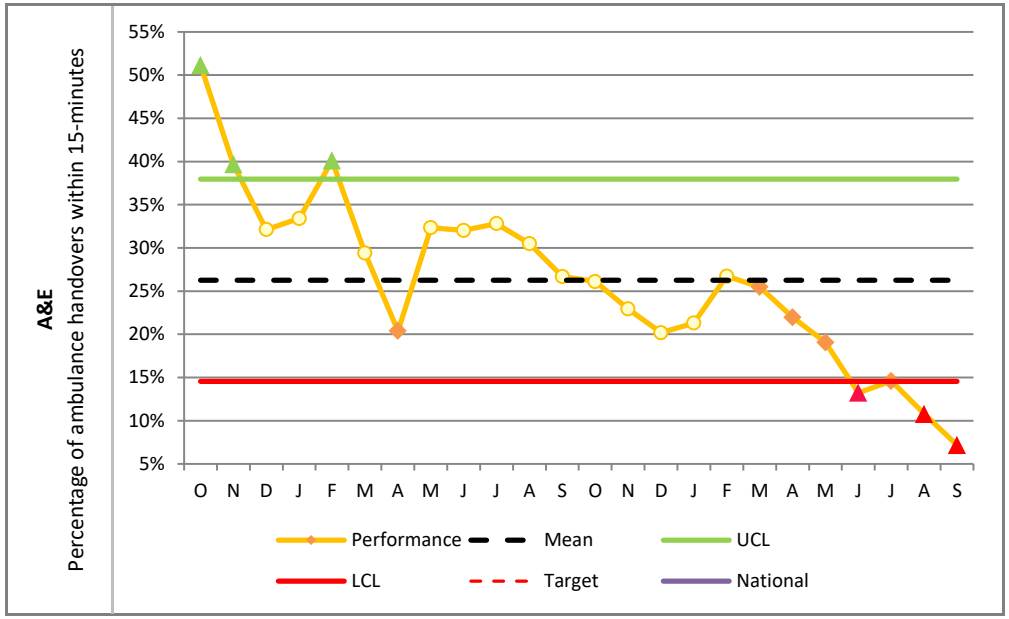
Domain	Metric	Target	Aug-21	Sep-21	Change	Trend
Other Emergency Department measures	Ambulance handovers (Arrival to Handover) Proportion within 15 minutes	-	11%	7%	▼	
	Ambulance handover breaches 30 minutes	334	812	783	▼	
	Ambulance handover breaches 60-minutes	73	334	336	▲	
	Attendance to admission conversion rate	-	29.7%	28.5%	▼	
	Time to initial assessment 95th centile	15	tbc	tbc	◀▶	
	Time to treatment Median	60	tbc	tbc	◀▶	
	Left department before being seen for treatment	5%	2.37%	3.86%	▲	
	Unplanned re-attendance rate	5%	6.19%	5.84%	▼	

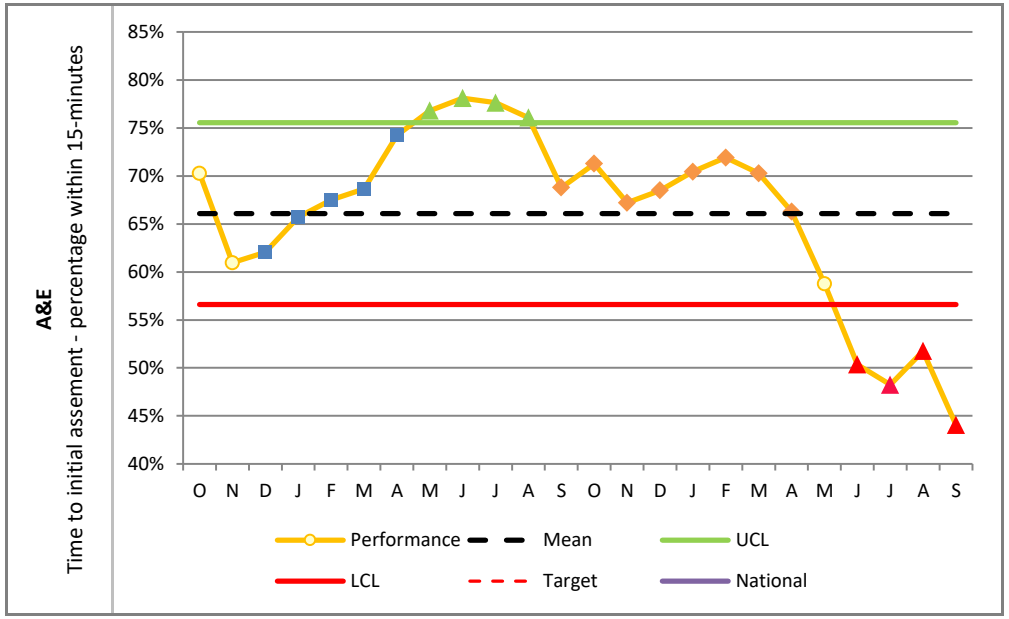


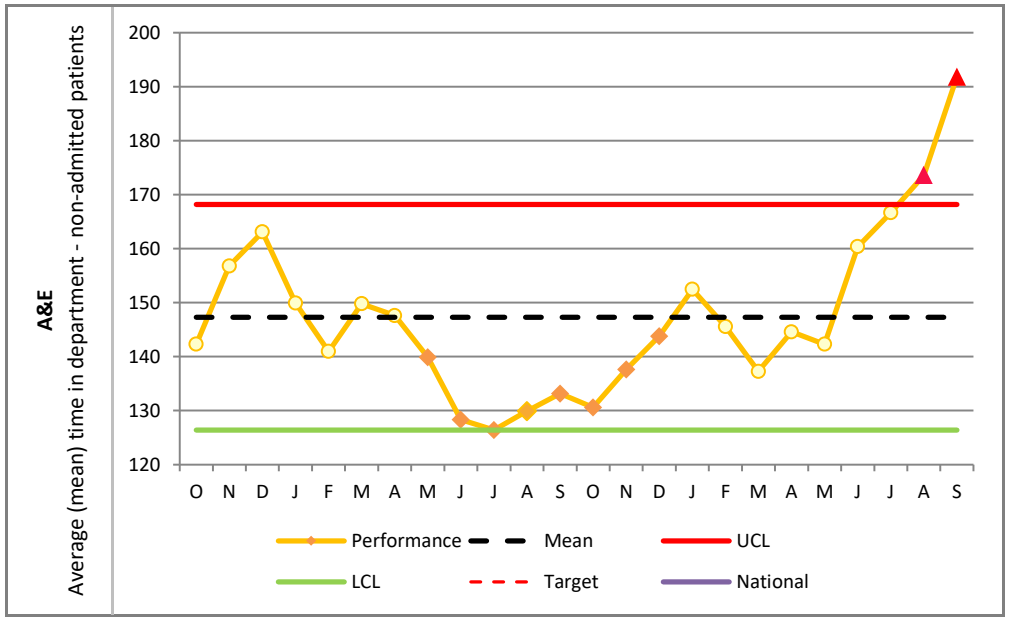


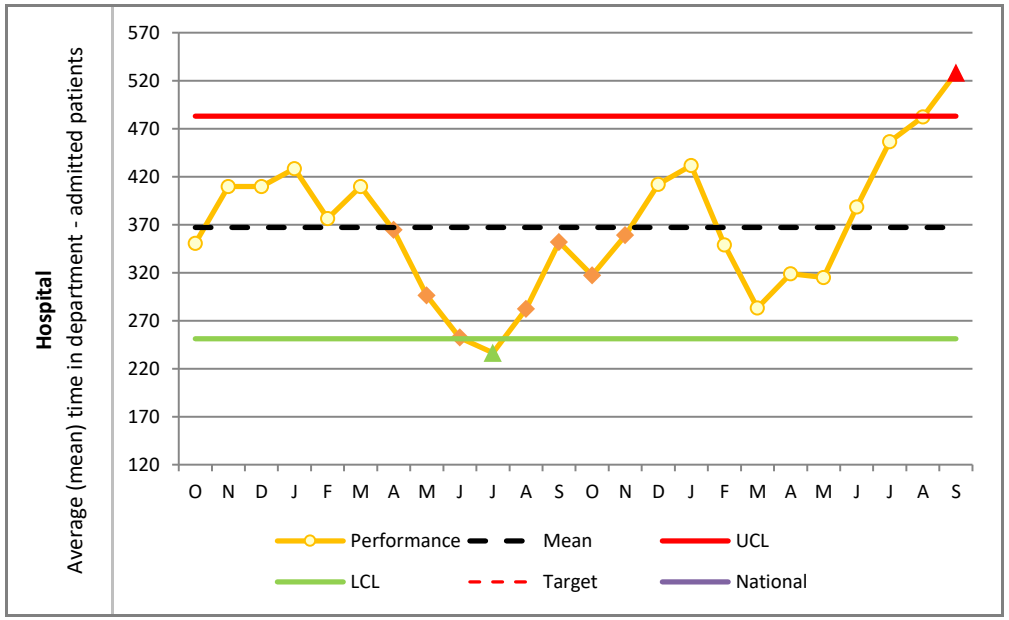
East and North Hertfordshire NHS Trust

New Emergency Department Standards



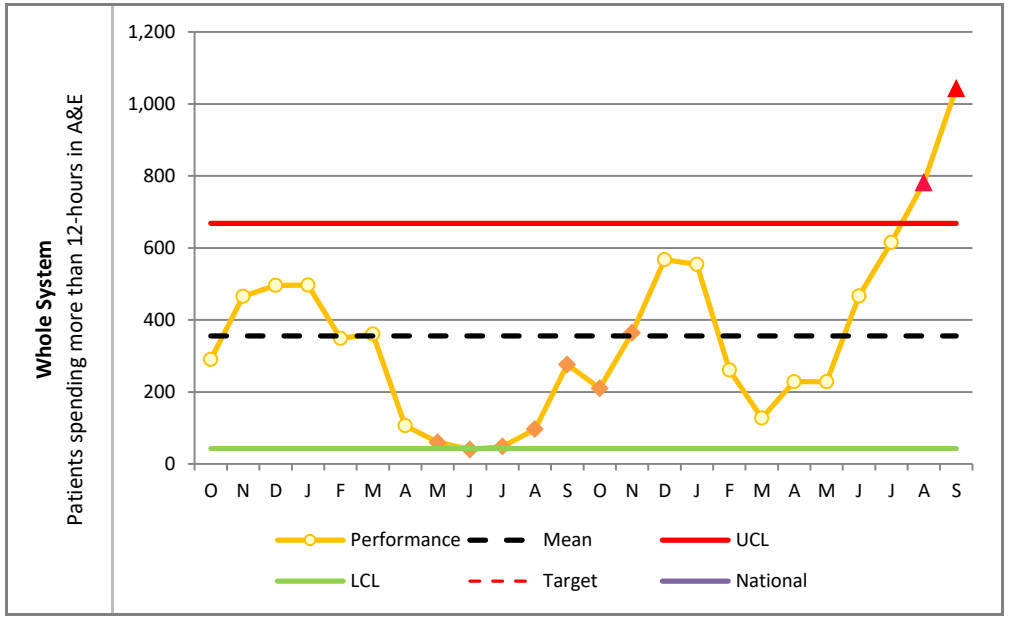






East and North Hertfordshire NHS Trust

New Emergency Department Standards



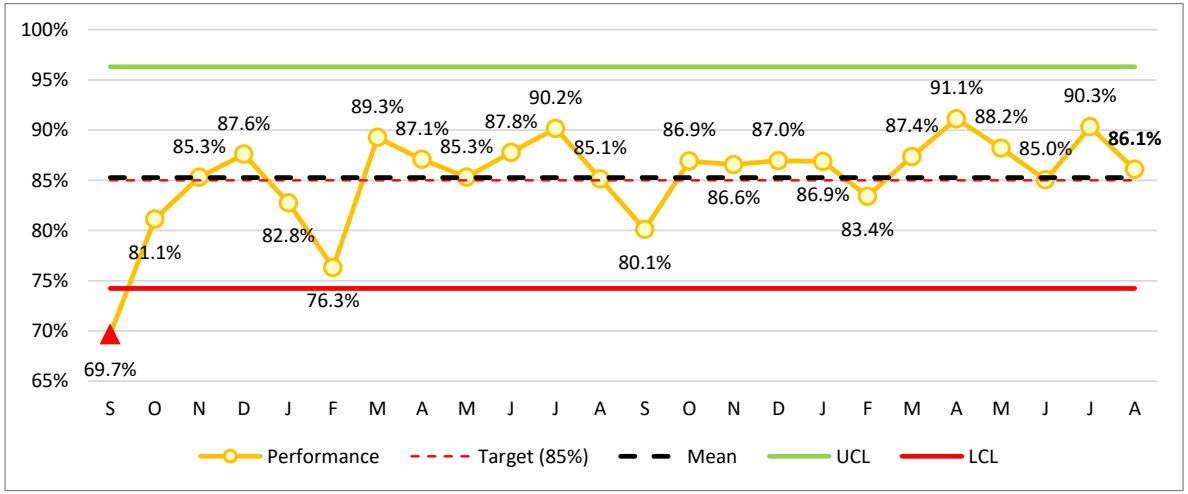
Responsive Services

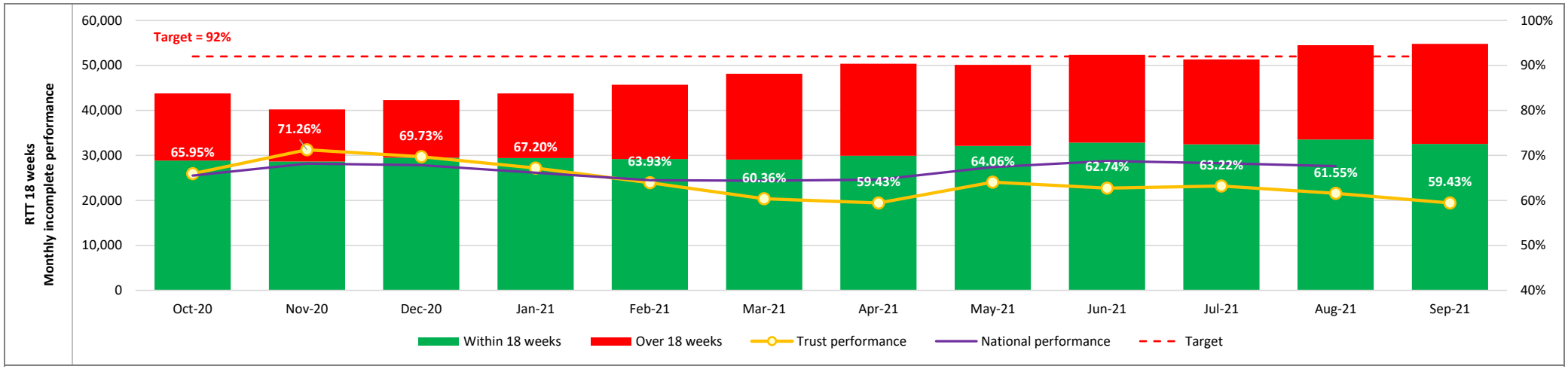
Cancer Waiting Times

East and North Hertfordshire NHS Trust

12-months' performance - all standards	Standard	Target	2020-21								2021-22					
			Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	Apr-21	May-21	Jun-21	Jul-21	Aug-21	YTD
	Two week waits Suspected cancer	93%	97.25%	96.74%	97.36%	98.12%	96.17%	98.00%	99.13%	97.26%	96.84%	97.86%	98.60%	97.62%	97.21%	97.66%
	Two week waits Breast symptomatic	93%	99.00%	96.36%	97.64%	93.33%	93.40%	100.00%	100.00%	97.08%	95.10%	95.24%	96.36%	100.00%	97.83%	96.83%
	31-day First definitive treatment	96%	98.48%	98.28%	98.68%	99.57%	99.05%	97.84%	96.97%	98.11%	99.51%	99.51%	96.69%	97.12%	96.93%	97.86%
	31-day subsequent treatment Anti-cancer drugs	98%	99.39%	100.00%	100.00%	100.00%	100.00%	99.42%	100.00%	99.86%	100.00%	100.00%	99.10%	99.48%	99.48%	99.57%
	31-day subsequent treatment Radiotherapy	94%	100.00%	100.00%	98.90%	99.63%	98.76%	98.51%	99.35%	98.87%	99.29%	98.63%	98.50%	98.94%	98.72%	98.80%
	31-day subsequent treatment Surgery	94%	90.00%	95.12%	95.45%	100.00%	75.00%	92.11%	87.76%	92.68%	84.44%	92.50%	88.89%	97.14%	86.67%	89.78%
	62-day GP referral to treatment	85%	80.10%	86.92%	86.55%	86.96%	86.87%	83.41%	87.36%	86.13%	91.12%	88.21%	85.04%	90.32%	86.10%	88.10%
	62-day Specialist screening service	90%	80.00%	100.00%	100.00%	84.62%	80.00%	75.00%	64.29%	69.34%	81.48%	76.47%	75.00%	77.78%	85.00%	78.63%

62-day GP referral to treatment Aug-21	Tumour Site	OK	Breach	Total	Perf.	104+ day waits
	Breast	14.0	3.0	17.0	82.35%	-
	Gynaecology	2.5	1.0	3.5	71.43%	-
	Haematology	4.0	2.0	6.0	66.67%	-
	Head and Neck	11.5	0.0	11.5	100.00%	-
	Lower GI	4.0	1.0	5.0	80.00%	-
	Lung	3.0	1.0	4.0	75.00%	-
	Other	5.0	0.0	5.0	100.00%	-
	Skin	18.5	3.0	21.5	86.05%	-
	Testicular	1.0	0.0	1.0	100.00%	-
	Upper GI	9.5	1.0	10.5	90.48%	-
	Urology	23.0	3.5	26.5	86.79%	-
	Total	**96.0**	**15.5**	**111.5**	86.10%	-

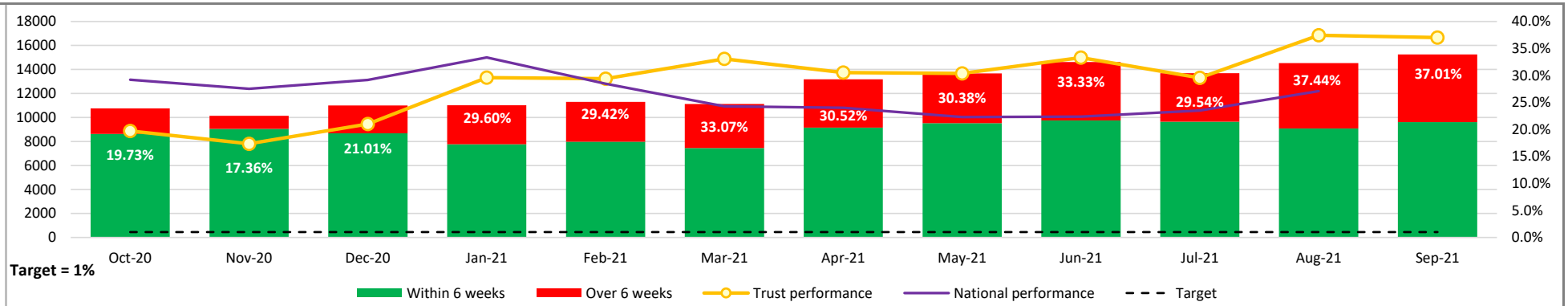




RTT 18 weeks
In-month performance by Specialty - Sep-21

Specialty	Clock Stops - Admitted			Clock Stops - Non-admitted			Incomplete pathways						Clock Starts
	Total	Performance	Over 52 weeks	Total	Performance	Over 52 weeks	Within 18 weeks	Over 18 weeks	Total	Performance	Over 52 weeks	Over 104 weeks	
General Surgery	203	55.67%	**19**	530	36.42%	8	1,784	1,558	3,342	**53.38%**	**201**	**1**	648
Urology	116	74.14%	**10**	718	40.25%	29	1,533	765	2,298	**66.71%**	**217**	**2**	667
Trauma & Orthopaedics	105	15.24%	**56**	1,268	32.18%	70	2,094	2,337	4,431	**47.26%**	**714**	**19**	772
Ear, Nose & Throat (ENT)	117	41.03%	**11**	1,558	22.46%	15	2,266	1,229	3,495	**64.84%**	**86**	**0**	914
Ophthalmology	179	15.64%	**31**	1,422	31.86%	35	3,432	3,491	6,923	**49.57%**	**223**	**1**	1,004
Oral Surgery	50	16.00%	**26**	460	24.35%	10	1,460	1,779	3,239	**45.08%**	**433**	**8**	414
Plastic Surgery	93	66.67%	**7**	952	48.11%	3	1,261	198	1,459	**86.43%**	**20**	**2**	848
Cardiothoracic Surgery	0	-	**0**	8	50.00%	0	16	2	18	**88.89%**	**0**	**0**	6
General Medicine	1	100.00%	**0**	18	50.00%	0	71	2	73	**97.26%**	**0**	**0**	54
Gastroenterology	182	70.88%	**22**	740	27.57%	89	2,734	3,320	6,054	**45.16%**	**710**	**2**	906
Cardiology	30	86.67%	**0**	920	39.24%	3	2,298	438	2,736	**83.99%**	**3**	**0**	898
Dermatology	2	100.00%	**0**	600	31.33%	5	1,150	731	1,881	**61.14%**	**3**	**0**	399
Thoracic Medicine	22	86.36%	**0**	574	36.41%	1	938	161	1,099	**85.35%**	**0**	**0**	378
Neurology	0	-	**0**	330	47.88%	1	474	14	488	**97.13%**	**1**	**0**	213
Rheumatology	2	50.00%	**1**	370	20.54%	2	751	309	1,060	**70.85%**	**6**	**0**	203
Geriatric Medicine	0	-	**0**	88	37.50%	0	181	34	215	**84.19%**	**0**	**0**	77
Gynaecology	71	36.62%	**15**	820	23.29%	1	2,171	1,129	3,300	**65.79%**	**35**	**0**	811
Other	167	37.13%	**45**	2,612	80.90%	92	7,952	4,731	12,683	**62.70%**	**607**	**30**	3,730
Total	**1,340**	**46.79%**	**243**	**8,300**	**69.99%**	**364**	**32,566**	**22,228**	**54,794**	**59.43%**	**3,259**	**65**	**12,942**

Diagnostics Waiting Times
Monthly waiting list performance



Diagnostics Waiting Times
In-month performance by Modality - Sep-21

Category	Modality	Patients still waiting at month end					Number of tests / procedures carried out during the month			
		Within 6 weeks	Over 6 weeks	Total	Performance	13+ weeks	Waiting List	Planned	Unscheduled	Total
Imaging	Magnetic Resonance Imaging	1,451	1,103	2,554	43.19%	32	1,822	149	1	**1,972**
	Computed Tomography	1,459	1,165	2,624	44.40%	356	2,997	606	1,496	**5,099**
	Non-obstetric ultrasound	4,433	2,130	6,563	32.45%	18	4,971	462	64	**5,497**
	DEXA Scan	529	695	1,224	56.78%	129	196	15	1	**212**
Physiological Measurement	Audiology - audiology assessments	28	24	52	46.15%	6	47	0	0	**47**
	Cardiology - echocardiography	767	131	898	14.59%	1	0	0	0	**0**
	Neurophysiology - peripheral neurophysiology	61	1	62	1.61%	0	89	0	0	**89**
	Respiratory physiology - sleep studies	129	6	135	4.44%	1	66	0	0	**66**
	Urodynamics - pressures & flows	61	37	98	37.76%	18	29	0	0	**29**
Endoscopy	Colonoscopy	311	202	513	39.38%	142	380	0	0	**380**
	Flexi sigmoidoscopy	110	69	179	38.55%	42	145	0	0	**145**
	Cystoscopy	34	2	36	5.56%	1	56	0	0	**56**
	Gastroscopy	235	80	315	25.40%	42	313	0	0	**313**
Total		**9,608**	**5,645**	**15,253**	**37.01%**	**788**	**11,111**	**1,232**	**1,562**	**13,905**

Responsive Services

Stroke Performance

East and North Hertfordshire NHS Trust

Domain	Metric	2021-22 Target	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend
Stroke	Trust SSNAP grade	A	C	C	C	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	80%	80.0%	87.5%	71.4%	100.0%	100.0%	85.7%	88.9%	87.5%	66.7%	100.0%	85.7%	100.0%	
	4-hours direct to Stroke unit from ED Actual	63%	54.0%	56.5%	52.0%	48.3%	28.1%	49.3%	61.0%	43.5%	64.4%	46.4%	36.1%	29.7%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	63%	55.3%	56.9%	52.1%	50.9%	29.5%	48.5%	66.7%	45.0%	65.5%	47.5%	34.8%	29.5%	
	Number of confirmed Strokes in-month on SSNAP	-	53	71	83	64	66	70	63	62	59	85	72	65	
	If applicable at least 90% of patients' stay is spent on a stroke unit	80%	86.5%	84.3%	87.7%	88.5%	92.3%	97.1%	93.4%	93.5%	93.2%	83.3%	87.3%	84.6%	
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	50%	45.3%	71.8%	55.4%	57.8%	47.0%	52.9%	55.6%	58.1%	49.2%	45.9%	56.9%	49.2%	
	Scanned within 12-hours - all Strokes	100%	92.5%	100.0%	100.0%	98.3%	97.0%	95.7%	98.2%	91.9%	96.6%	94.1%	97.2%	93.8%	
	% of all stroke patients who receive thrombolysis	11%	5.7%	23.2%	11.0%	11.3%	10.6%	5.7%	11.3%	3.2%	3.4%	8.2%	4.2%	9.2%	
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	70%	0.0%	62.5%	77.8%	71.4%	85.7%	25.0%	14.3%	0.0%	50.0%	57.1%	0.0%	16.7%	
	Discharged with JCP	80%	79.4%	93.3%	92.6%	94.7%	85.0%	91.3%	75.8%	91.9%	87.0%	52.6%	72.3%	81.6%	
	Discharged with ESD	40%	40.0%	49.0%	69.2%	76.7%	80.0%	62.5%	56.8%	73.0%	73.9%	60.7%	70.2%	71.7%	

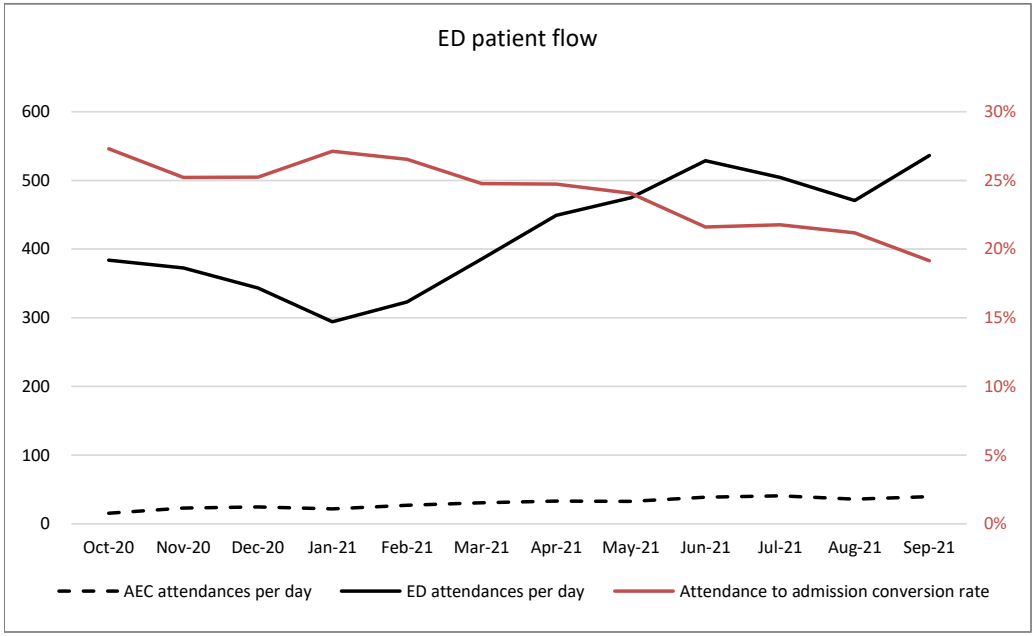
Breaches Sep-21	Breach reasons:			Breach Reasons: 45 In Hours: 17 Out of Hours: 28
		• Challenging Diagnosis/Complex Patients = 4 • Late referral = 5 • Share Care Transfers = 3 • Operational/Pathway (ED delays) = 16	• Bed Capacity = 10 • Inpatient Stroke = 2 • Patient Related / Clinical Need = 3 • COVID POC = 2 • Other = 0	

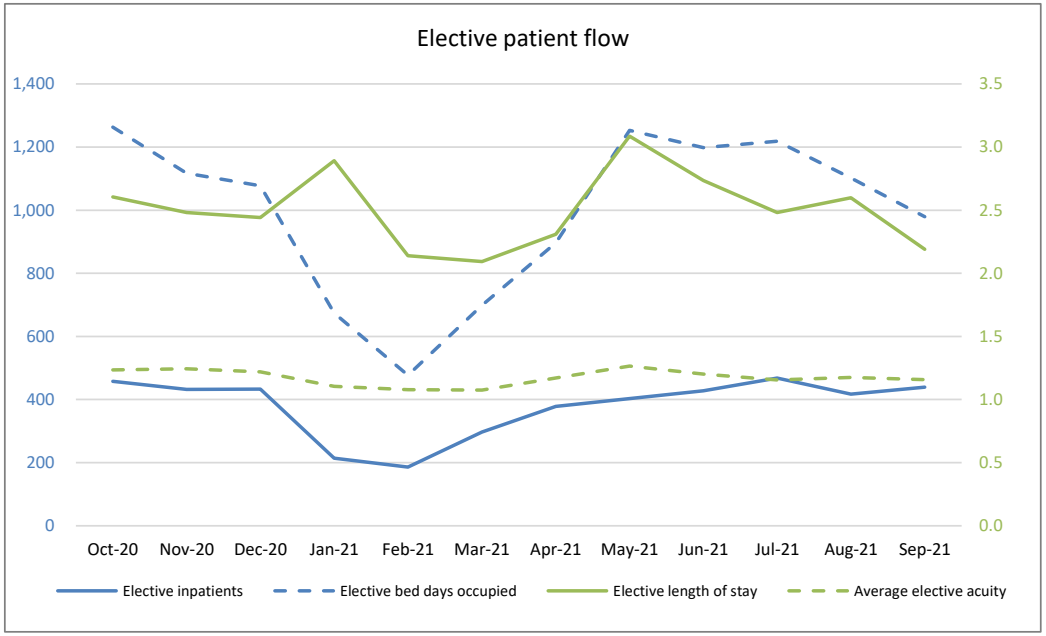
Responsive Services

East and North Hertfordshire NHS Trust

Patient Flow

Domain	Metric	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend
Emergency Department Flow Indicators	A&E & UCC attendances	11,904	11,173	10,639	9,119	9,044	11,955	13,470	14,720	15,859	15,633	14,594	16,086	
	Attendance to admission conversion rate	27.3%	25.2%	25.2%	27.1%	26.5%	24.8%	24.7%	24.1%	21.6%	21.8%	21.2%	19.2%	
	ED attendances per day	384	372	343	294	323	386	449	475	529	504	471	536	
	AEC attendances per day	15	23	24	22	27	31	33	33	39	41	36	40	
	4-hour target performance %	84.5%	82.4%	78.2%	75.2%	78.8%	85.2%	82.8%	84.1%	78.6%	74.8%	73.3%	69.5%	
	Time to initial assessment 95th centile	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	
	Ambulance handover breaches 30-minutes	350	507	634	467	327	274	380	341	586	548	812	783	

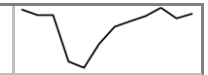
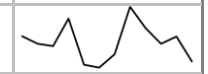
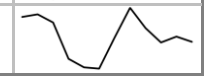
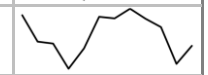
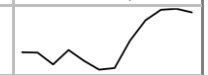
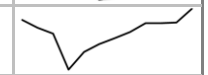
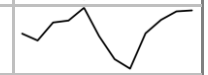




Responsive Services

Patient Flow

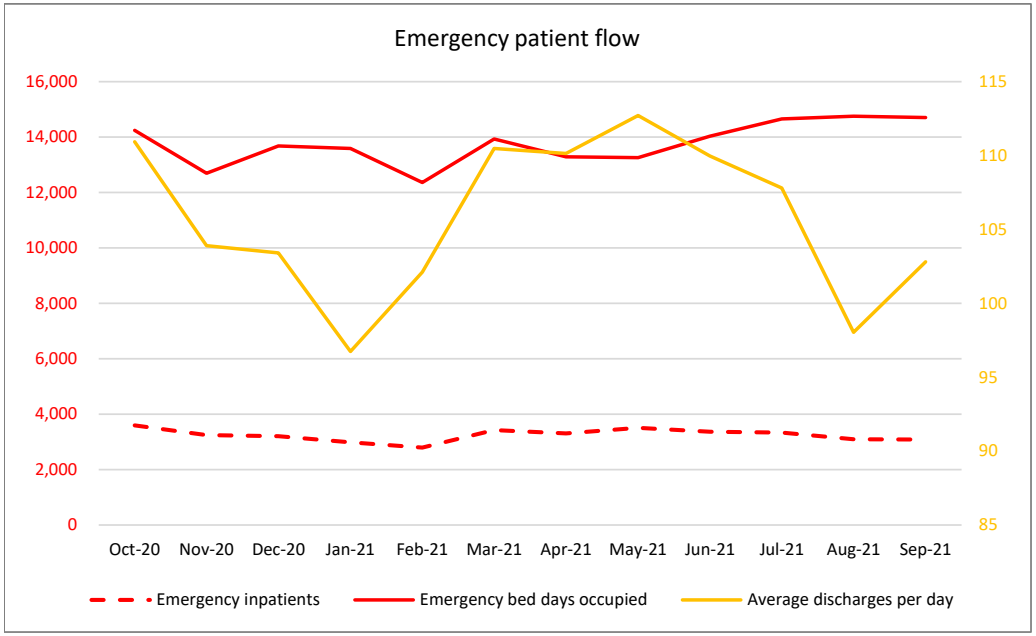
East and North Hertfordshire NHS Trust

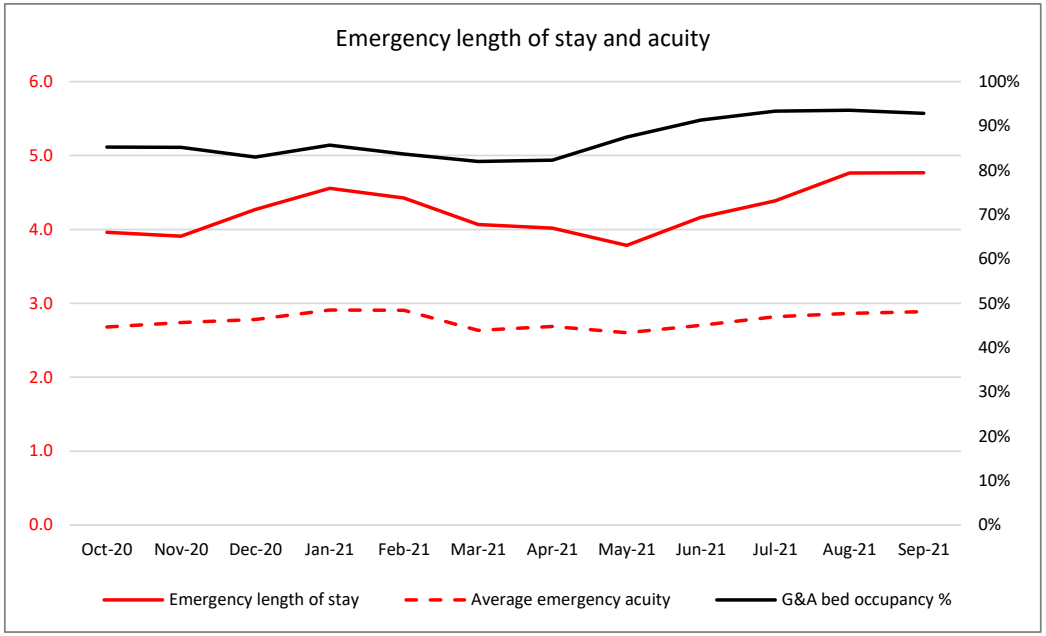
Domain	Metric	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend
Elective Inpatient Flow Indicators	Elective inpatients	458	432	433	214	186	297	378	403	428	468	417	439	
	Elective bed days occupied	1,263	1,117	1,077	674	477	699	896	1,253	1,198	1,218	1,102	979	
	Elective length of stay	2.6	2.5	2.4	2.9	2.1	2.1	2.3	3.1	2.7	2.5	2.6	2.2	
	Daycase rate %	87.7%	87.7%	87.0%	89.2%	89.6%	89.1%	87.9%	89.0%	89.8%	89.1%	88.7%	88.2%	
	Average elective acuity	1.24	1.24	1.22	1.11	1.08	1.07	1.17	1.26	1.20	1.16	1.17	1.16	
Emergency Flow Indicators	Emergency inpatients	3,595	3,246	3,202	2,981	2,794	3,425	3,308	3,502	3,368	3,340	3,097	3,084	
	Average discharges per day	111	104	103	97	102	110	110	113	110	108	98	103	
	Emergency bed days occupied	14,242	12,692	13,676	13,588	12,361	13,926	13,290	13,253	14,033	14,650	14,753	14,702	
	Emergency length of stay	4.0	3.9	4.3	4.6	4.4	4.1	4.0	3.8	4.2	4.4	4.8	4.8	
	Average emergency acuity	2.7	2.7	2.8	2.9	2.9	2.6	2.7	2.6	2.7	2.8	2.9	2.9	
	G&A bed occupancy %	85%	85%	83%	86%	84%	82%	82%	88%	91%	93%	94%	93%	
	Patients discharged via Discharge Lounge	554	504	465	234	348	398	436	477	534	533	538	627	
	Discharges before midday	9.6%	10.4%	10.2%	9.9%	11.3%	10.5%	11.9%	11.7%	11.3%	11.1%	11.4%	12.7%	
	Weekend discharges	16.8%	15.0%	13.9%	16.3%	13.0%	14.3%	16.1%	17.3%	14.8%	18.8%	14.5%	15.1%	
	Proportion of beds occupied by patients with length of stay over 14 days	18.4%	17.9%	19.3%	19.4%	20.4%	18.2%	16.6%	15.9%	18.5%	19.4%	20.1%	20.1%	
	Proportion of beds occupied by patients with length of stay over 21 days	9.8%	8.5%	9.5%	9.4%	10.8%	9.1%	8.9%	8.1%	9.6%	9.9%	10.9%	9.9%	

Responsive Services

East and North Hertfordshire NHS Trust

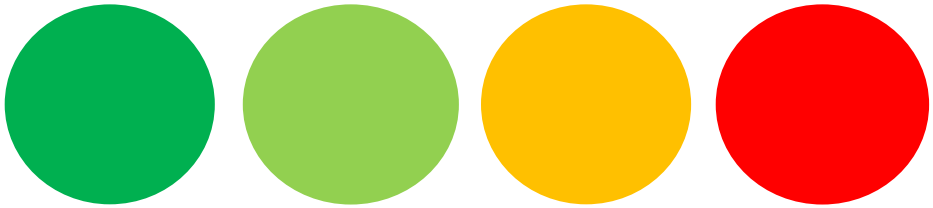
Patient Flow





People Report

Month 06 | 2021-22



Key Issues

Work

- Vacancy rate overall has remained at 6.3% (392 vacancies). There are the same number of people in post this month compared to last month, this is offset by a reduction in overall recruitable establishment of 23. There were 134 starters in month, and 97 leavers in month.
- Nursing vacancy rate has decreased from 3.6% to 3.2% (58 vacancies). There are 131 more nurses in post than 12 months ago.
- Agency spend increased by 41k, this was not consistent with reduction of 14% in agency worked hours. Estates & Facilities saw the largest increase in agency usage (36%) in month, all other staff groups utilised less agency hours against M5.
- Overall temporary staffing requested hours decreased by 3% which is consistent with substantive unavailability improving by 0.2% to 70.4%.
- 2,653 hours were requested through the roster to special patients in M5, this equates to 22% of additional duty hours.

Grow

- Statutory training compliance is now at 88%. The number of staff with 100% compliance has decreased to 57% from 62%.
- The recorded appraisal rate is static at 61%. Digital version of Grow Together (Appraisal) launched on ENH Academy. Some technical reporting issue mean appraisals are not showing in data set.
- International recruitment continues at pace.
- Significant ongoing input into the Integrated Strategic Business Planning that will require additional education and development across the organisation.
- CPD funding for all staff groups allocated with the training needs analysis process to start next month.

Thrive

- Staff survey is currently open with a response rate at 30%, with 4 weeks remaining.
- Staff turnover has increased from 12.5% to 12.8%. One of the highest reasons for leaving was due to people moving on to further education or training which went from 1.8% to 12.8%. This relates to the increase number support staff who have left substantive posts to pursue clinical training. The second highest reason is work life balance which has jumped up from the previous month however it is only slightly higher the 12 month average.
- Duration of suspensions has increased to 143 days due to closure of some shorter suspensions cases. disciplinary and grievance case average have both reduced in month due to closures.

Care

- Sickness absence rate has increased by 0.3% with the highest levels of absence in theatres and renal.
- Over 3000 staff have received their COVID booster and flu vaccines.

Executive Response

Work

- There are 273 people in the pipeline, including 51 doctors, 24 care support workers and 32 Allied Health Professionals (AHPs). International Nurse recruitment continues to be a focus with an aim to recruit 100 nurses in the coming months, as well as planning underway to collaborate further with the ICS in preparation for 2022.
- Candidate experience rating remains high at 4.6 out of 5 for the past 5 months and time to hire remain below target at 9 weeks (against a target of 10 weeks). Inclusion Ambassador Programme continues to gain momentum with plans to include an IA on all 8a and above posts by December 2021.
- Hotspots for Nursing recruitment are Paeds & Maternity, plans are underway to address sustainable workforce for the future including Paeds OSCE programme, Paeds Recruitment Uk wide campaign and a collaborative approach to Midwifery international recruitment with the ICS.
- Medical establishment remains static with a vacancy rate of 5% (50 vacancies) and targeted campaigns are underway on the hard to recruit to posts as appropriate.

Executive Response

Work (cont'd)

- The Trust is now 84% compliant against NHSE/I clinical levels of attainment with a rostering system, in addition 84% of junior doctors and 45% of consultants are live on eRoster with the remaining implementation of new areas progressing well against the action plan. Procurement for new Medical Rostering software should be concluded in November 2021 with any implementation/data migration occurring alongside the current Allocate contract until May 2022.
- The Temporary Staffing Division on behalf of ICS trusts is underway against a clear work plan focusing on 4 key objectives for 21-22. These focus on Pay Alignment, Demand Management, Shared Locum Bank and Grow Your Own Bank which focuses on increasing the pool of available bank staff - a progress paper will be shared in October's FPPC meeting.

Grow

- ENH Academy continues to develop and evolve with project plan for development.
- The 'Grow Together' module for performance and talent conversations launched on ENH Academy in June. Reporting issues within academy have been worked through and data update process being established.
- CPD policy refresh to start next month and further work to start on CPD portal.
- The education space in the trust to be prioritised for education activity to ensure face to face training can continue against demand. Plans to be taken to space utilisation group.
- Reorganisation of the team and recruiting into vacant posts will ensure capacity and capability across the teams.
- Associate director for people capability appointed substantively and interim Head of Clinical Education in post.

Thrive

- Changing culture through conversations launches in November with the start of staff listening events and reciprocal mentoring programme.
- The trust has developed a rage of recognition schemes due to be launched in November including a recognition award which will feed into staff awards, a 'pay it forward' scheme to offer thanks to colleagues going above and beyond and recognition of length of service.
- Work continues with the service lines to review a range of cultural indicators including staff survey results as part of the development of the new integrated strategic business plan. Themes for focus include Equality, Diversity and Inclusion; Safe Environment; and Health and Wellbeing.
- The integrated business planning process continues with this work transitioning to the new people business partner model of delivery.
- The average duration suspensions has increased due to the closure of three cases with one long standing case expected close next month.
- Work continues to take place within the ERAS team to improve service delivery and ensure managers are able to access training, coaching and support.
- The national staff survey remains open. A comprehensive communication strategy is in place to ensure the maximum number of staff are encouraged to complete the survey. Managers are regularly reminded to enable their teams to take time to complete the survey.

Care

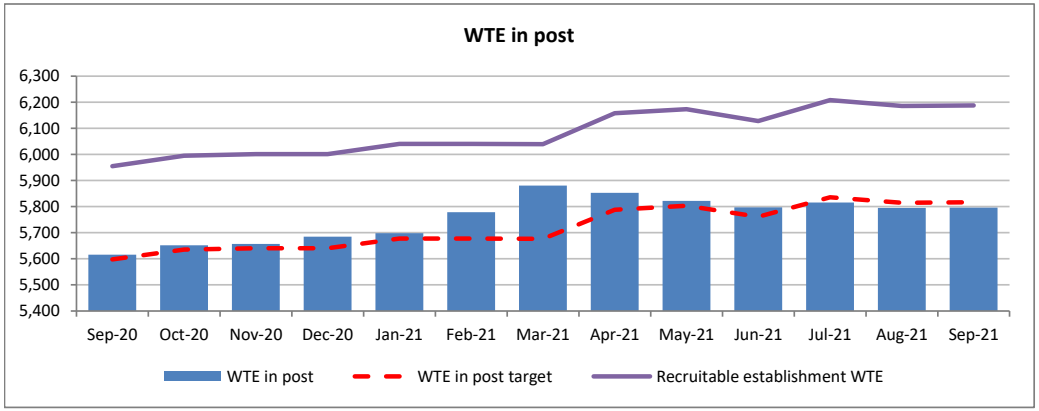
- Mental health first aid training continues to be popular, with the aim of having 200 trained MHFA across the trust.
- The health and wellbeing decision making council have identified that most staff prefer to be 'looked after' or supported by their team or line manager rather than in large anonymous groups. Managers are therefore being supported to offer local support and are encouraged to identify a wellbeing champion their teams.
- Over 3000 staff have had their COVID booster and flu vaccine with bookings and drop in sessions continuing.
- Hot spot areas are being supported to identify any bespoke support required and address themes of absence and attendance.

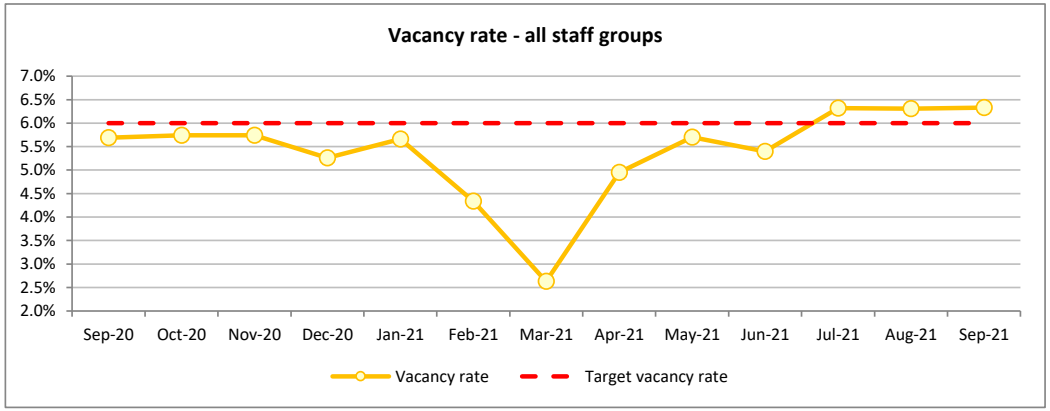
People Report

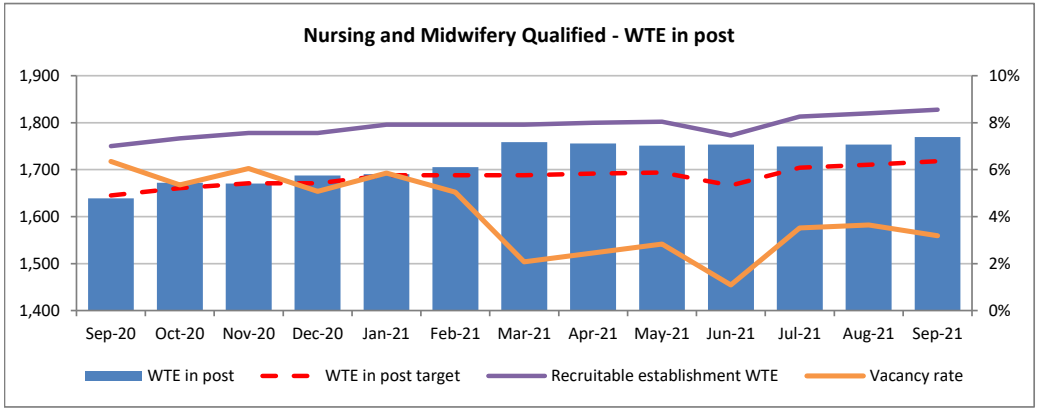
Work Together

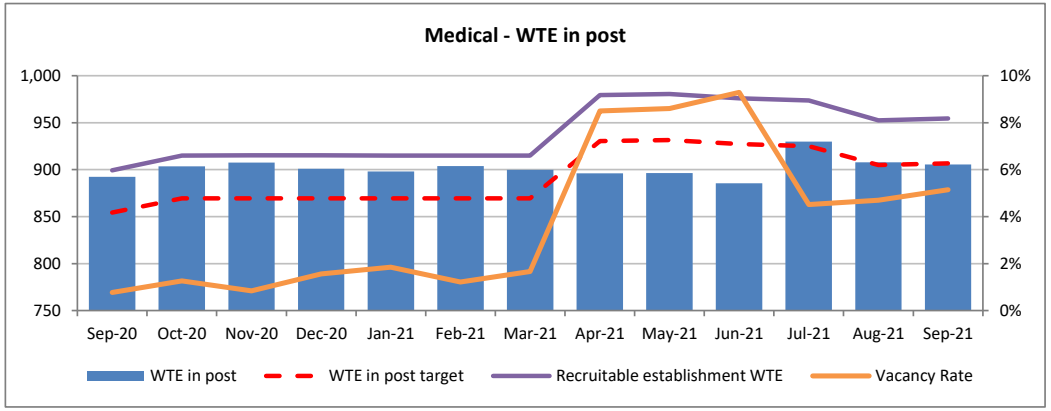
East and North Hertfordshire NHS Trust

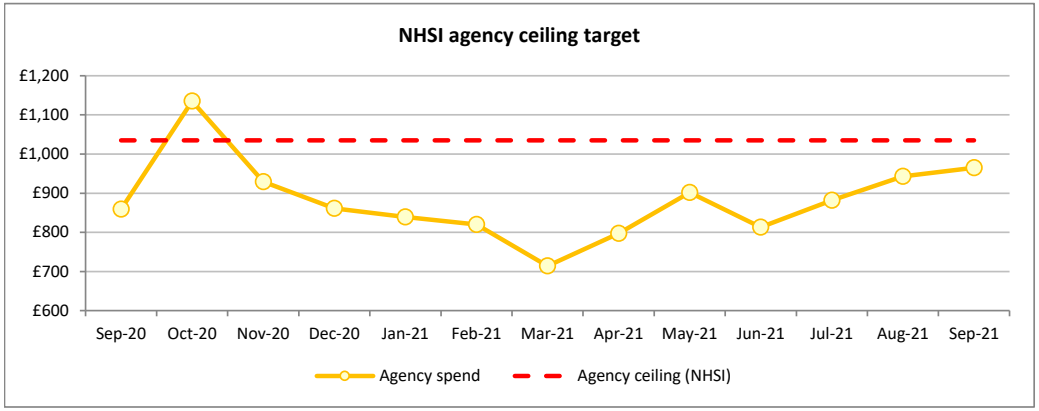
Domain	Metric	Target	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend
Work	Vacancy Rate	6%	5.7%	5.7%	5.7%	5.3%	5.7%	4.3%	2.6%	5.0%	5.7%	5.4%	6.3%	6.3%	6.3%	
	Time to hire (weeks)	10	12.0	12.0	13.0	9.0	11.0	10.0	10.0	11.0	11.0	10.0	9.0	9.0	9.0	
	Recruitment experience	4	4.3	4.4	4.7	4.5	4.6	4.5	4.4	4.7	4.7	4.7	4.7	4.7	4.6	
	Relative likelihood of white applicant being shortlisted and appointed over BAME applicant	1	1.40	1.40			2.00			2.00			1.43			
	Relative likelihood of non-disabled applicant being shortlisted and appointed over disabled applicant	1	0.84	0.57			0.70			1.20			1.62			
	Agency Spend (% of WTE)	4%	3.0%	3.3%	4.3%	3.5%	3.4%	3.2%	3.3%	3.5%	2.9%	3.3%	3.3%	3.6%	3.1%	
	Bank Spend (% of WTE)	10%	9.2%	7.9%	9.7%	9.9%	10.5%	11.6%	8.6%	10.4%	8.4%	8.1%	7.9%	9.2%	8.5%	
	% of Clinical Workforce (AFC) on eRoster	> 90%												82.0%	82.0%	
	% of Medical & Dental on eRoster	60%												83.0%	83.0%	
	% of Rosters Approved more than 6 weeks in advance (NHS E/I recommended)	< 21%												62.0%	43.5%	
	Pulse survey Flexibility	55%	59.5%	56.0%			60.0%			64.3%			56.6%			

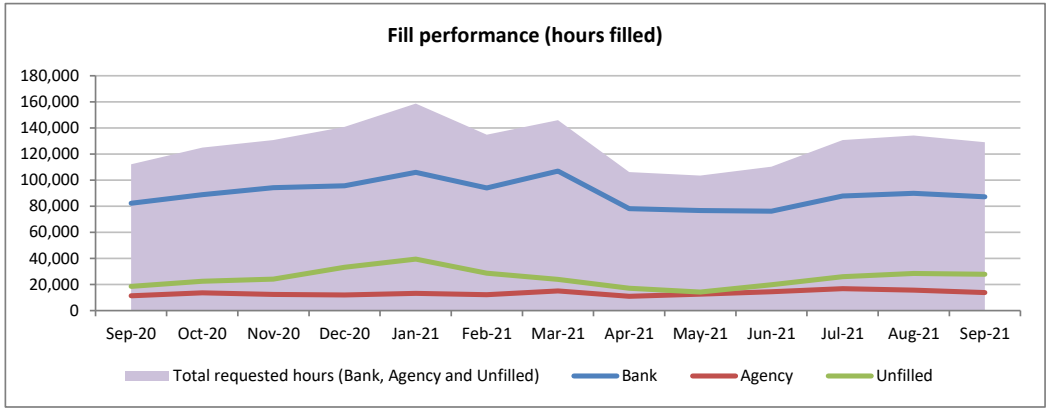


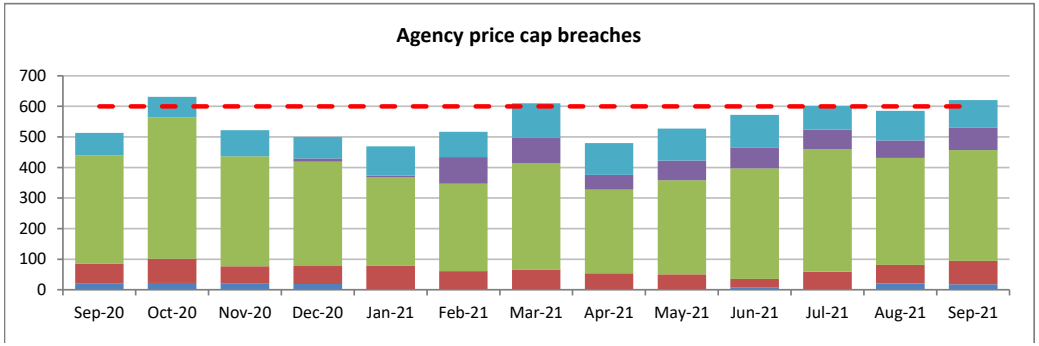


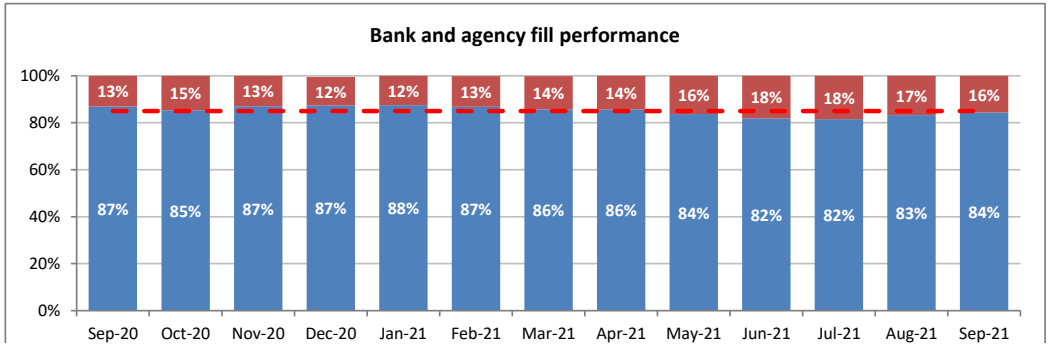

Nursing and Midwifery Qualified - WTE in post
1,900
1,800
1,700
1,600
1,500
1,400
10%
8%
6%
4%
2%
0%
Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21
WTE in post
WTE in post target
Recruitable establishment WTE
Vacancy rate

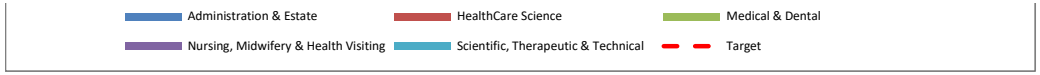

Medical - WTE in post
1,000
950
900
850
800
750
10%
8%
6%
4%
2%
0%
Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21
WTE in post
WTE in post target
Recruitable establishment WTE
Vacancy Rate


NHSI agency ceiling target
£1,200
£1,100
£1,000
£900
£800
£700
£600
Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21
Agency spend
Agency ceiling (NHSI)


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


Agency price cap breaches
700
600
500
400
300
200
100
0
Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21


Bank and agency fill performance
100%
80%
60%
40%
20%
0%
13% 15% 13% 12% 12% 13% 14% 14% 16% 18% 18% 17% 16%
87% 85% 87% 87% 88% 87% 86% 86% 84% 82% 82% 83% 84%
Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21


Administration & Estate
HealthCare Science
Medical & Dental
Nursing, Midwifery & Health Visiting
Scientific, Therapeutic & Technical
Target

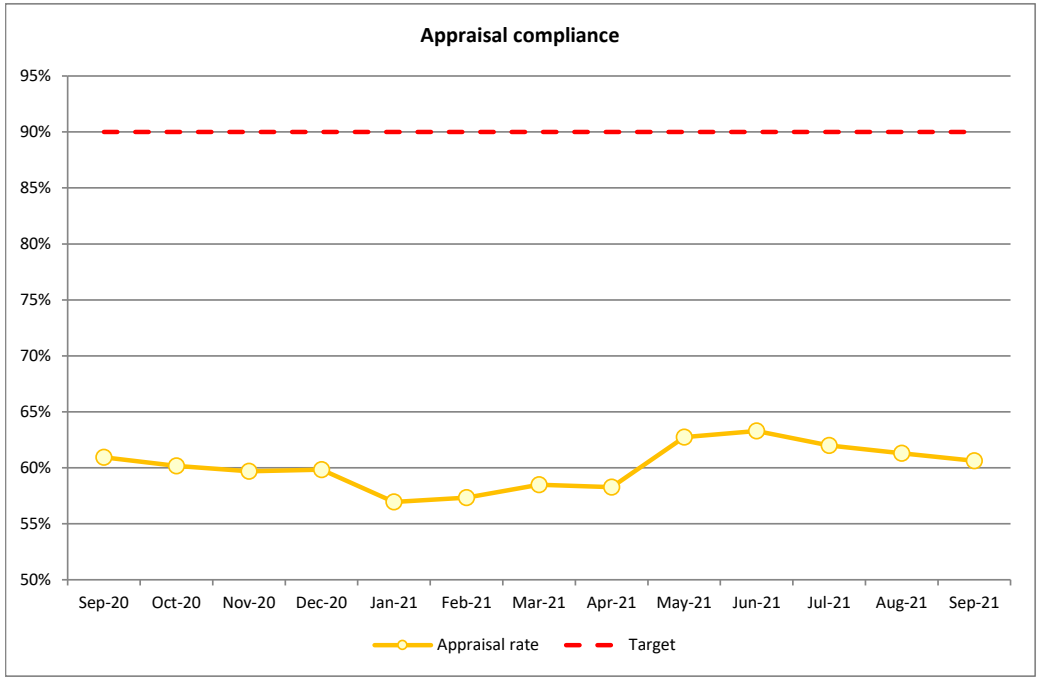

Bank
Agency
Target bank fill

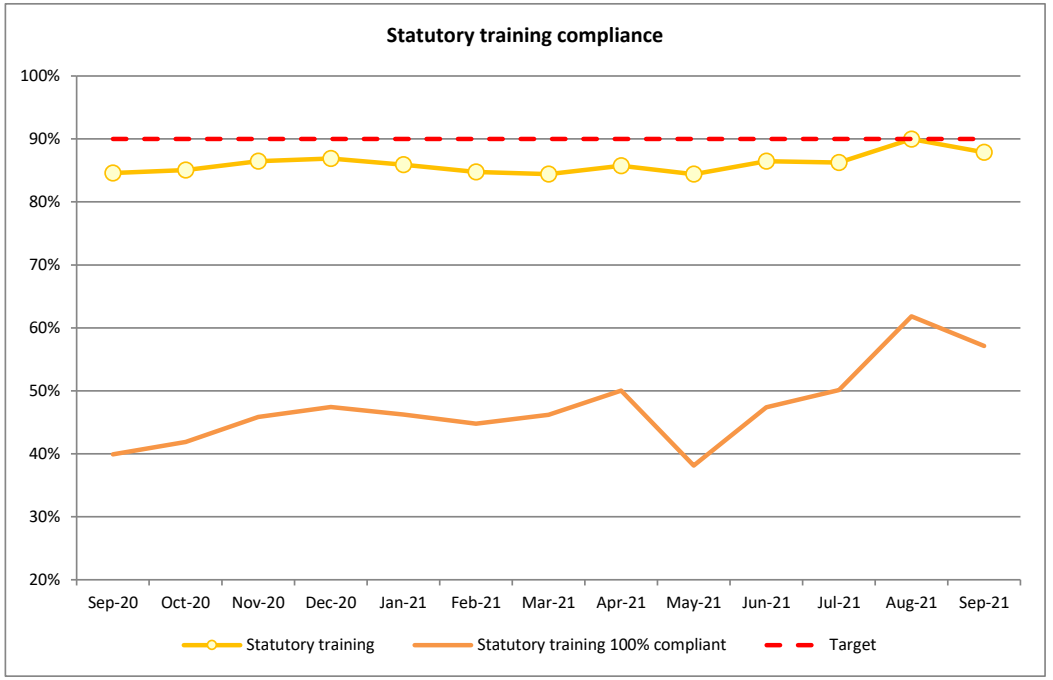
People Report

Grow Together

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend
Grow	Statutory & mandatory training compliance rate	90%	84.6%	85.1%	86.5%	86.9%	85.9%	84.8%	84.4%	85.8%	84.4%	86.5%	86.3%	90.0%	87.9%	
	Appraisal rate	90%	61.0%	60.2%	59.7%	59.8%	57.0%	57.3%	58.5%	58.3%	62.7%	63.3%	62.0%	61.3%	60.6%	
	Pulse survey Training and development opportunities	55%	53.0%	54.0%			52.1%			55.4%			55.1%			
	Pulse survey Talent management	55%	47.1%	55.0%			51.3%			61.8%			55.4%			
	Likelihood of training and development opportunities (BAME)	1	tbc	tbc			tbc			tbc			tbc			
	Likelihood of training and development opportunities (Disability)	1	tbc	tbc			tbc			tbc			tbc			



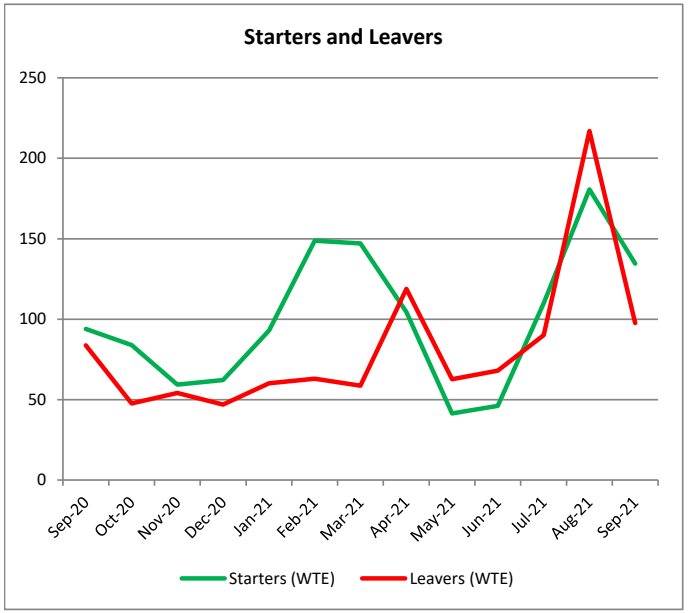


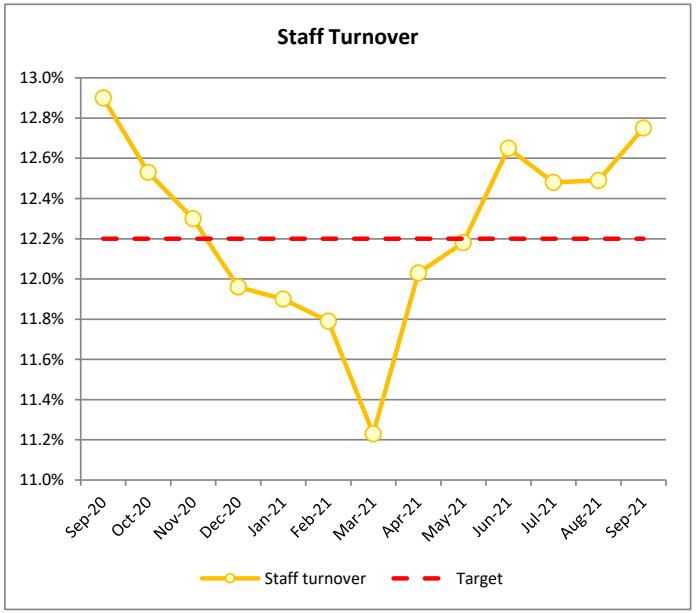
People Report

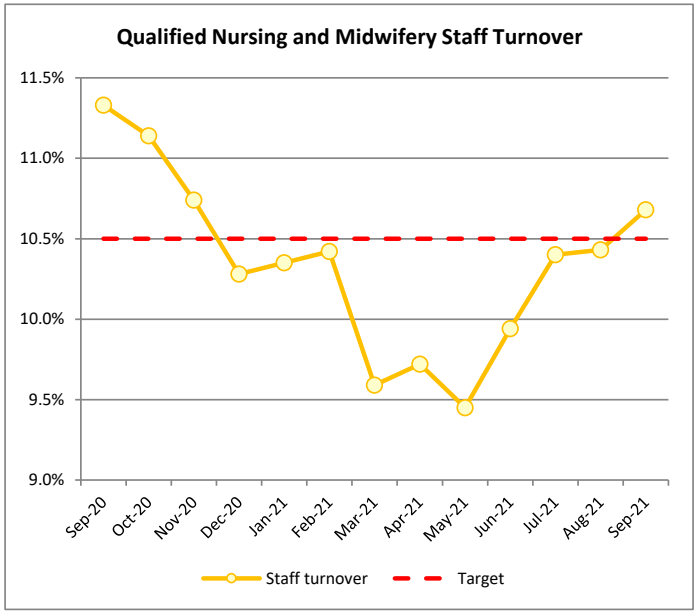
Thrive Together

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend
Thrive	Pulse survey My leader	75%	81.4%	87.0%			79.8%			85.5%			79.8%			
	Pulse survey Harnessing individuality	60%	59.8%	59.0%			57.7%			61.8%			52.8%			
	Pulse Survey Not experiencing discrimination	95%	72.2%	90.5%			68.4%			75.9%			70.8%			
	Turnover Rate	12.2%	12.9%	12.5%	12.3%	12.0%	11.9%	11.8%	11.2%	12.0%	12.2%	12.7%	12.5%	12.5%	12.8%	
	Model employer targets (% achieved)	100%	66%	83%			67%			50%			67%			
	Average length of suspension (days)	20	0	29	60	22.5	33	43	37	59	57.2	76.6	105	96	142.5	
	Average length of Disciplinary (excluding suspensions) (days)	60	158	154	87	74.3	96	102	148	168	63	47.7	86	74	71.6	
	Average length of Grievance (including dignity at work) (days)	60	2	20	46	22	114	86	91	82	80	86	74	37.9	23.25	





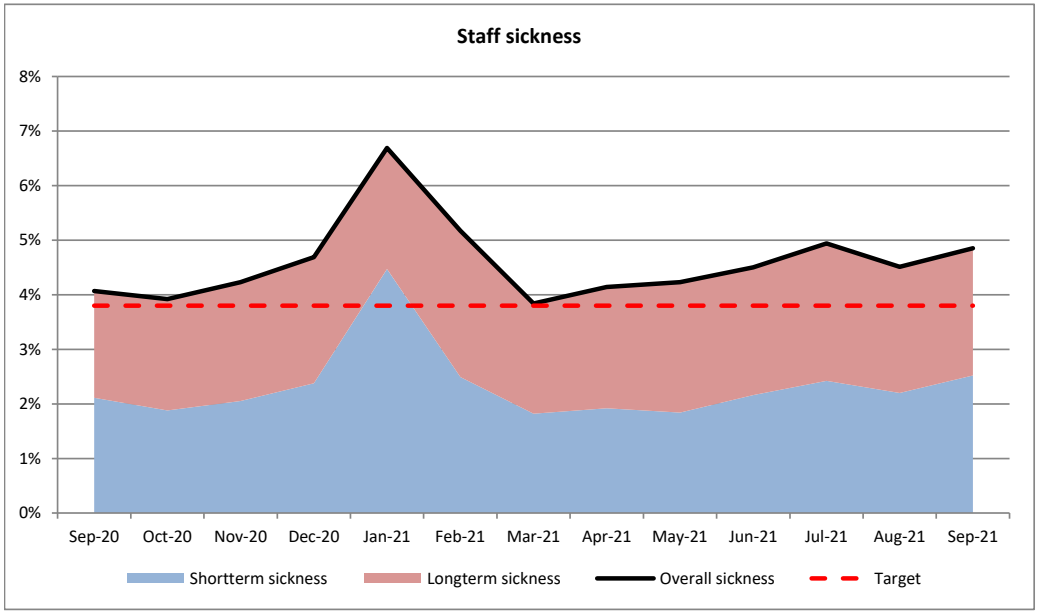


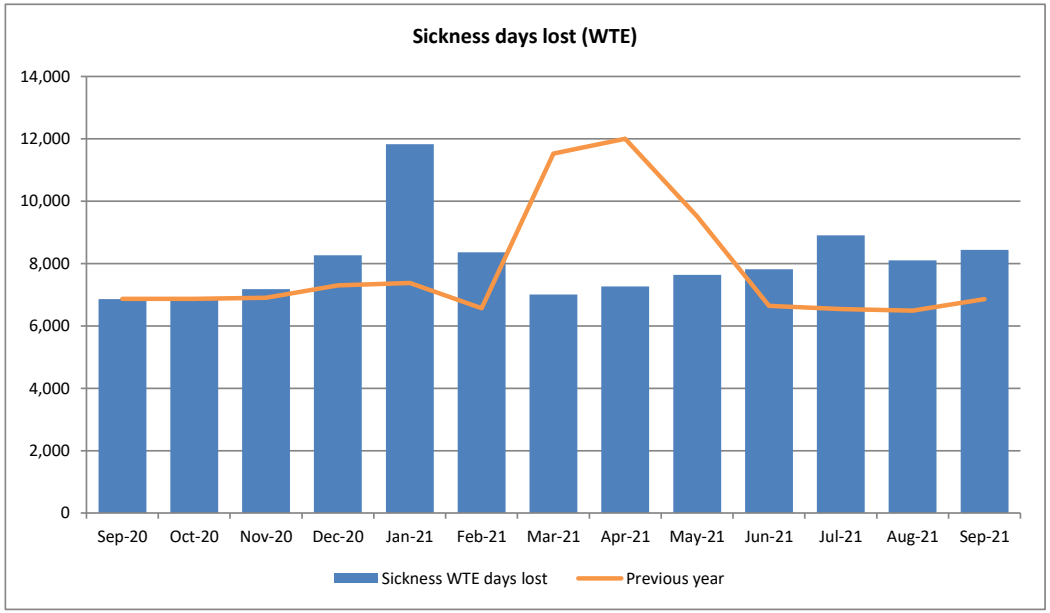
People Report

Care Together

East and North Hertfordshire NHS Trust

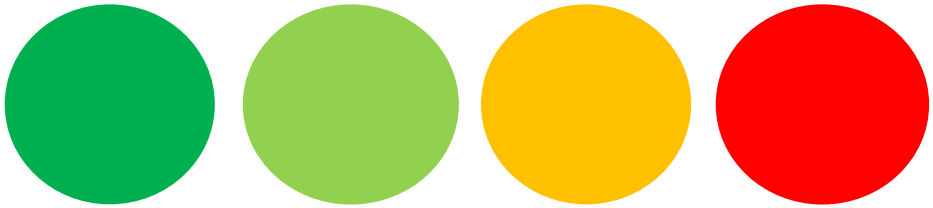
Domain	Metric	Target	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend
Care	Pulse survey Well-being	70%	74.8%	51.0%			68.6%			78.9%			71.5%			
	Pulse survey Reasonable adjustments	50%	67.4%	74.0%			60.4%			88.7%			91.4%			
	Staff FFT Recommend as a place to work	60%	51.1%	61.0%			47.8%			56.6%			41.7%			
	Staff FFT Recommend as a place of care	70%	76.0%	71.0%			70.3%			72.7%			65.9%			
	Sickness Rate	3.8%	4.07%	3.92%	4.23%	4.69%	6.69%	5.17%	3.84%	4.14%	4.23%	4.50%	4.94%	4.51%	4.85%	
	Sickness FTE Days Lost	6,777	6,861	6,863	7,183	8,270	11,825	8,357	7,005	7,265	7,633	7,818	8,905	8,102	8,437	
	Mental health related absence (days lost)	1,650	1,799	1,981	1,725	1,716	1,743	1,691	1,684	1,798	1,702	1,899	1,945	1,583	1,725	
	MSK related absence (days lost)	1,285	1,431	1,478	1,580	1,554	1,347	1,315	1,165	1,120	1,170	1,325	1,260	1,196	1,152	





Sustainable Services

Month 06 | 2021-22

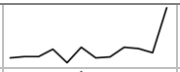
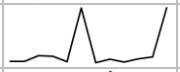
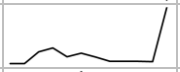
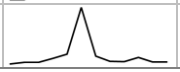
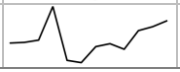


Key Issues	Executive Response
• NHSE has confirmed that the financial framework for 21/22 will be separate and distinct for both halves of the financial year. At present only funding arrangements for the first six months (H1) have been specified, with arrangements for the second half of the year set to be confirmed in September. • The funding settlements for individual NHS organisations during H1 are based upon a rollover of block, top up and other COVID monies received as key components of financial plans for the second half of 20/21. These allocations included approved distributions of System COVID and growth funds which have provided ENHT with coverage for a range of unavoidable costs resulting from the pandemic, along with funding resources to enable the recovery of elective services. • In April 2021 the Finance Committee considered and approved a balanced budget for H1. This was prepared based on the funding settlement outlined above and in alignment with Trust and national business planning guidelines and priorities. The Trust's financial plan is one component of an overarching balanced system wide financial plan that was submitted to NHSE. Monthly ICS Directors of Finance meetings remain in place for the system to ensure that in year delivery across partner organisations is co-ordinated to ensure that collective financial balance is achieved. • During H1 21/22 the delivery of improved levels of elective activity is incentivised through the implementation of the Elective Recovery Fund (ERF). This will enable providers to earn additional non recurrent funds should activity achievement exceed specified thresholds. The Trust operational and finance & information teams worked to agree and implement delivery plans that will deliver stepped increases in elective activity levels. In addition, the Trust has led work across the ICS to construct a financial and activity monitoring mechanism to allow the system to track delivery and achievement on a monthly basis. • ERF performance in Q1 was strong, although has proved more challenging in Q2. ERF performance is subject to validation by DH / NHSE against aggregate system targets as well as gateway criteria. During July it was confirmed that ERF delivery thresholds would be adjusted upwards to 95% for Month 4 onwards and until the end of the H1 reporting period. It is likely that this will significantly impair both Trust and system opportunity to generate ERF monies to support further elective expansion. The Trust was worked with ICS colleagues to determine a framework whereby ERF funds earned by the system will be distributed. • At Month 6 the Trust reports a small YTD surplus of £0.4m. • The management of the Trust pay-bill will require careful focus. A combination of improved recruitment and reduced turnover has seen the number of permanent staff employed by the Trust increase by 262 WTE's since April 2020. Consequently, vacancy rates across most staff groups and departments have fallen to an all-time low. In response the Trust will need to carefully and flexibly manage the deployment of new staff, the approval of the use of temporary staffing resources and the pace of future domestic and international recruitment to ensure that it is able to manage its workforce within the boundaries of its approved pay budget.	• The Trust maintains robust mechanisms and systems for monitoring financial performance and maintaining good governance. In addition to its formal Committee structure, the Director of Finance also chairs monthly finance boards with each of the Divisions. Attendance and participation at each of these sessions has been high and they have proved effective in identifying and managing plan delivery and the agreement of remedial action where appropriate. In addition, monthly Delivery Oversight Group (DOG) meetings focusing upon finance and workforce issues have been helpful in promoting mature engagement and discussion of policy and planning issues. • The Trust acknowledges H2 planning guidance that has identified the need for all providers to deliver a stepped change in efficiency levels in the second half of the year. In response the Trust has set out a CIP planning framework to deliver savings plans across divisions and corporate services to the value of £5.7m. • To monitor and drive the delivery of improved elective activity during H1, the Trust has set up a weekly Demand and Capacity review session. This is chaired by the Managing Director of Planned Services supported by senior corporate officers. The session reviews progress at a service line level, discussing opportunities for improvement or how obstacles to achievement can be addressed. • As a component part of the new 'ENHT Academy' learning management system the Finance and Information team have refreshed and significantly expanded the range of business skills training materials that are available to budget holders and managers to assist in the discharge of their responsibilities. This suite of materials will continue to be monitored, expanded, and enhanced to support both individual and collective training needs and improved business decision making across the Trust. • Finance and Corporate teams continue to work to develop and enhance business partnering models to support divisional teams. • The availability of accurate and timely business intelligence and modelling has been key in supporting the Trusts agile and flexible response to the rapidly changing environment. 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 remain an important component in the Trust's recovery process. • A key priority for the Trust's Finance and Information Team in 21/22 is the development of an effective suite of Population Health Management (PHM) Data products. This specific project co-ordinated by the AD for Planning will be crucial in terms of assisting the Trust and system partners in understanding the patient needs and outcome and provide a framework to set out opportunities for transformation and change. An internal steering group to co-ordinate PHM activities has been set up and project updates and briefing will be provided to Committees on a regular basis. • The Trust continues to work with place-based partners to explore new models of service collaboration moving forward. A number of specific areas of project work have been agreed to test the effectiveness of these models.

Sustainable Services

Finance Plan Performance

East and North Hertfordshire NHS Trust

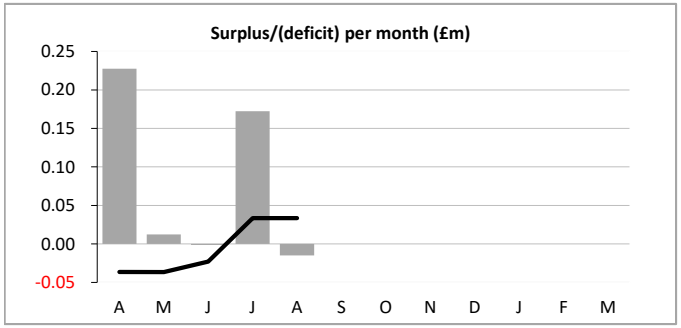
Domain	Metric	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	36.4	36.5	36.5	37.1	36.0	37.3	36.4	36.5	37.3	37.2	36.8	40.6		221.4	224.7	3.4
	Other Income Earned	2.9	3.1	2.6	2.9	2.9	10.0	2.6	7.3	5.3	6.0	4.0	5.3		19.7	30.6	10.9
	Pay Costs	26.6	26.6	27.2	27.1	26.6	31.6	26.5	26.8	26.6	26.9	27.0	31.6		167.2	165.4	-1.7
	Non Pay Costs inc Financing	17.0	17.2	16.4	17.2	16.3	17.9	16.6	21.2	20.3	20.4	18.1	19.2		100.2	115.9	15.6
	Underlying Surplus / (Deficit)	-4.3	-4.3	-4.4	-4.3	-4.0	-2.1	-4.1	-4.3	-4.3	-4.1	-4.3	-5.0		-26.4	-26.0	0.4
	Top up payments	4.2	4.2	4.4	4.4	4.3	4.4	4.3	4.3	4.3	4.3	4.3	5.0		26.4	26.4	0.0
	Retained Surplus / Deficit	-0.10	-0.02	-0.03	0.13	0.31	2.24	0.23	0.01	-0.00	0.17	-0.01	-0.02		-0.00	0.38	0.4
Paybill Metrics	Substantive Pay Costs	22.8	22.8	23.2	22.0	23.4	27.8	22.8	23.0	23.0	22.6	22.6	26.2		155.6	140.2	-15.4
	Premium Pay Costs Overtime & WLI	0.2	0.3	0.3	0.3	0.1	0.0	0.7	0.7	0.7	0.8	1.0	0.9		1.7	4.8	3.1
	Premium Pay Costs Bank Costs	2.6	2.6	2.8	3.7	2.3	3.0	2.2	2.2	2.1	2.5	2.5	3.5		7.4	15.0	7.6
	Premium Pay Costs Agency Costs	1.1	0.9	0.9	1.2	0.8	0.8	0.8	0.9	0.8	1.0	1.0	1.0		2.5	5.4	3.0
	Premium Pay Costs As % of Paybill	14.3%	14.4%	14.7%	18.9%	12.2%	11.9%	13.9%	14.3%	13.6%	15.9%	16.4%	17.1%		6.9%	15.2%	8.3%

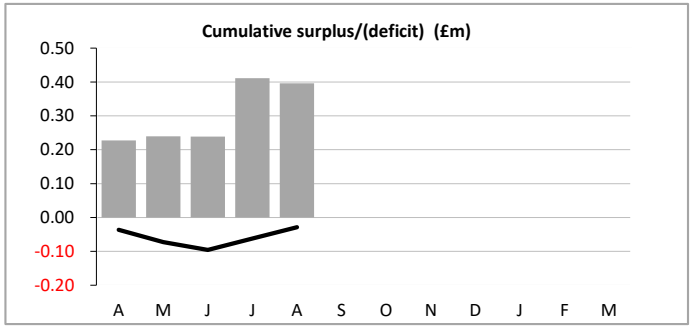
Sustainable Services

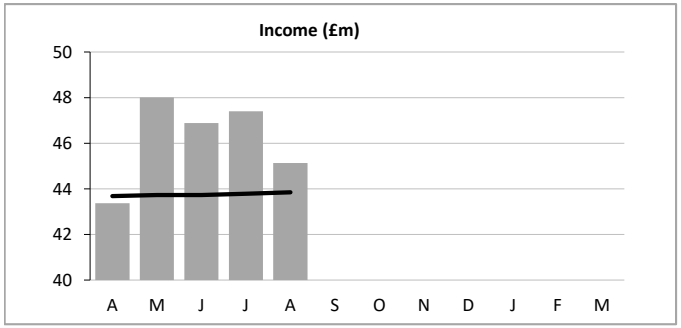
Finance Plan Performance

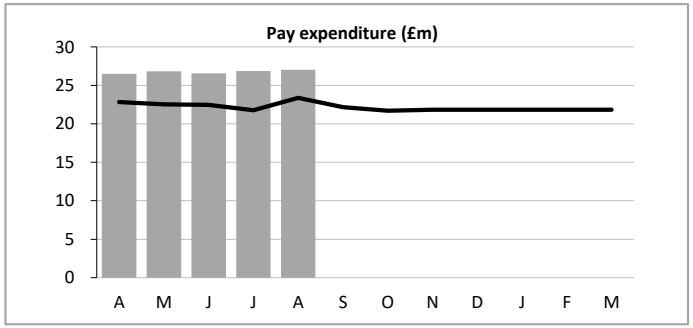
East and North Hertfordshire NHS Trust

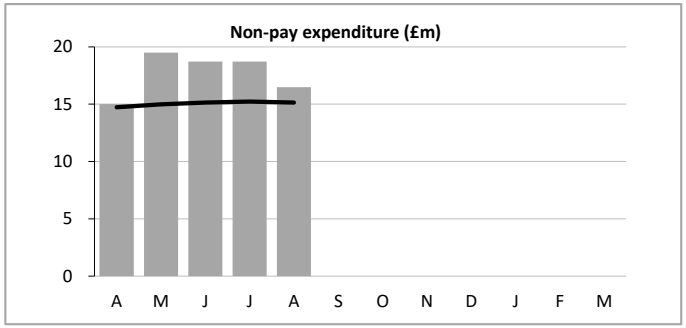
Domain	Metric	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	n/a	n/a	n/a	n/a	n/a	n/a	N/A	N/A	N/A	N/A	N/A	N/A	———	1	n/a	
	Liquid Ratio (Days)	n/a	n/a	n/a	n/a	n/a	n/a	N/A	N/A	N/A	N/A	N/A	N/A	———	1	n/a	
	I&E Margin	n/a	n/a	n/a	n/a	n/a	n/a	N/A	N/A	N/A	N/A	N/A	N/A	———	1	n/a	
	Distance from Plan	n/a	n/a	n/a	n/a	n/a	n/a	N/A	N/A	N/A	N/A	N/A	N/A	———	1	n/a	
	Agency Spend vs. Ceiling	n/a	n/a	n/a	n/a	n/a	n/a	N/A	N/A	N/A	N/A	N/A	N/A	———	1	n/a	
	Overall Finance Metric	n/a	n/a	n/a	n/a	n/a	n/a	N/A	N/A	N/A	N/A	N/A	N/A	———	1	n/a	











Sustainable Services

SLA Contracts - Income Performance

East and North Hertfordshire NHS Trust

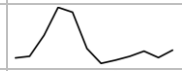
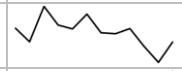
		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Point of Delivery	A&E Attendances	2,372	2,937	565	14,229	16,374	2,144
	Daycases	3,121	2,879	-242	18,726	17,800	-926
	Inpatient Elective	1,942	1,505	-438	11,654	9,854	-1,800
	Inpatient Non Elective	9,813	8,673	-1,141	58,880	52,853	-6,027
	Maternity	2,582	2,586	4	15,493	15,590	97
	Other	6,654	7,359	705	21,113	36,019	14,906
	Outpatient First	2,188	2,137	-51	13,125	11,823	-1,302
	Outpatient Follow Ups	2,541	3,105	564	15,246	18,262	3,016
	Outpatient Procedures	1,165	1,253	88	6,991	7,658	667
	NHSE Block Impact	0	2,104	2,104	0	1,711	1,711
	Other SLAs	65	65	0	390	390	0
	Block	847	847	0	5,082	5,082	0
	Drugs & Devices	3,950	4,395	445	23,702	26,294	2,593
	Chemotherapy Delivery	611	598	-13	3,664	3,910	246
	Radiotherapy	1,138	1,090	-48	6,826	6,582	-244
	Renal Dialysis	1,194	1,171	-23	7,165	7,040	-125
	Total	40,182	42,703	2,521	222,283	237,240	14,957

		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Commissioner	East & North Herts CCG	21,742	21,742	-0	130,452	130,452	-0
	Specialist Commissioning	8,329	8,745	416	49,974	52,566	2,592
	Bedfordshire CCG	2,826	2,826	0	16,958	16,957	-0
	Herts Valleys CCG	1,411	1,411	-0	8,465	8,465	-0
	Cancer Drugs Fund	590	821	231	3,541	5,069	1,528
	Luton CCG	0	0	0	0	0	0
	PH - Screening	381	172	-208	2,284	1,084	-1,200
	Other	4,903	6,986	2,082	10,609	22,646	12,037
	Total	40,182	42,703	2,520	222,283	237,240	14,956
By Division	Cancer Services	6,332	6,671	339	37,991	41,166	3,176
	Unplanned Care	19,077	19,093	16	114,462	112,045	-2,417
	Planned Care	11,431	10,752	-678	68,586	65,453	-3,133
	Other	3,342	6,186	2,843	1,245	18,576	17,331
	Total	40,182	42,703	2,520	222,283	237,240	14,956

Sustainable Services

Activity and Productivity

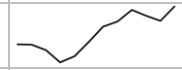
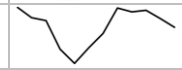
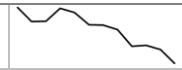
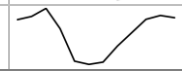
East and North Hertfordshire NHS Trust

Domain	Metric	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	11,432	10,984	10,632	8,951	8,840	11,769	13,380	14,556	15,595	15,337	14,627	16,104		80,324	89,599	9,275
	Chemotherapy Atts	2,313	2,315	2,689	2,232	2,268	2,759	2,457	2,452	2,789	2,677	2,536	2,207		13,616	15,118	1,502
	Critical Care (Adult) - OBD's	631	649	870	1,170	1,117	731	574	608	650	702	635	712		3,701	3,881	180
	Critical Care (Paeds) - OBD's	580	584	339	268	372	492	466	709	484	451	518	433		3,330	3,061	-269
	Daycases	3,447	3,205	2,949	1,920	1,926	2,730	2,827	3,282	3,856	4,003	3,327	3,330		23,742	20,625	-3,117
	Elective Inpatients	485	450	441	233	223	334	405	467	478	539	503	476		3,370	2,868	-502
	Emergency Inpatients	4,074	3,933	3,936	3,652	3,556	4,371	4,640	4,822	4,842	48,580	4,701	4,656		25,684	72,241	46,557
	Home Dialysis	165	163	155	148	139	176	154	176	156	177	202	154		992	1,019	27
	Hospital Dialysis	7,522	6,977	7,521	7,215	6,673	7,557	6,260	6,309	6,317	6,677	6,517	6,496		38,660	38,576	-84
	Maternity Births	436	408	368	437	350	448	415	440	441	475	473	455		2,651	2,699	48
	Maternity Bookings	535	490	609	546	533	583	520	517	534	475	422	489		3,003	2,957	-46
	Outpatient First	6,175	6,496	5,698	3,145	3,018	4,334	7,952	7,707	8,577	7,990	7,485	8,820		54,642	48,531	-6,111
	Outpatient Follow Up	15,126	14,801	13,378	5,977	6,012	7,277	20,723	18,476	20,193	18,855	17,334	19,470		115,991	115,051	-940
	Outpatient procedures	6,804	7,008	6,570	4,788	4,859	5,680	6,727	6,731	7,762	8,090	7,212	7,201		44,493	43,723	-770
	Radiotherapy Fractions	3,459	3,503	4,321	3,583	3,585	4,233	3,771	4,071	4,704	4,184	4,037	4,162		25,838	24,929	-909

Sustainable Services

Activity and Productivity

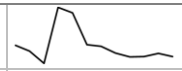
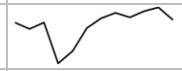
East and North Hertfordshire NHS Trust

Domain	Metric	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	179	174	161	108	107	133	161	194	195	204	179	172		215	186	-29
	Emergency Spells per Day	112	103	99	92	96	106	106	109	108	103	95	99		140	395	254
	ED Attendances per Day	369	366	343	289	316	380	446	470	520	495	472	537		439	490	51
	Outpatient Atts per Working Day	1,278	1,348	1,221	696	694	752	1,007	1,133	1,136	1,138	1,126	1,166		1,707	1,645	-62
	Elective Bed Days Used	1,263	1,117	1,077	674	477	699	896	1,253	1,198	1,218	1,102	979		8,270	6,646	-1,624
	Emergency Bed Days Used	14,242	12,692	13,676	13,588	12,361	13,926	13,290	13,253	14,033	14,650	14,753	14,702		94,335	84,681	-9,654
Efficiency	Admission Rate from A&E	27%	25%	25%	27%	27%	25%	25%	24%	22%	22%	21%	19%		23.3%	22.1%	-1.2%
	Emergency - Length of Stay	4.0	3.9	4.3	4.6	4.4	4.1	4.0	3.8	4.2	4.4	4.8	4.8		3.8	4.3	0.5
	Emergency - Casemix Value	2,678	2,740	2,783	2,909	2,907	2,635	2,687	2,602	2,704	2,819	2,864	2,886		2,321	2,760	440
	Elective - Length of Stay	2.6	2.5	2.4	2.9	2.1	2.1	2.3	3.1	2.7	2.5	2.6	2.2		2.5	2.6	0.1
	Elective - Casemix Value	1,235	1,244	1,219	1,105	1,078	1,075	1,172	1,265	1,201	1,156	1,175	1,158		1,117	1,188	71
	Elective Surgical DC Rate %	87.7%	87.7%	87.0%	89.2%	89.6%	89.1%	87.9%	89.0%	89.8%	89.1%	88.7%	88.2%		85%	89%	3.8%
	Outpatient DNA Rate % - 1st	6.7%	7.8%	6.5%	8.3%	7.1%	7.0%	12.8%	11.5%	11.0%	12.3%	12.4%	11.8%		6.4%	11.9%	5.5%
	Outpatient DNA Rate % - FUP	6.7%	7.8%	6.5%	8.3%	7.1%	7.0%	6.0%	4.9%	5.2%	5.6%	6.4%	5.9%		7.1%	5.6%	-1.5%
	Outpatient Cancel Rate % - Patient	7.8%	8.0%	8.6%	7.2%	5.1%	4.9%	5.1%	6.1%	7.0%	7.8%	8.1%	7.9%		5.6%	7.0%	1.4%

Sustainable Services

Activity and Productivity

East and North Hertfordshire NHS Trust

Domain	Metric	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	8.8%	8.3%	7.4%	11.8%	11.4%	8.9%	8.7%	8.2%	7.9%	7.9%	8.2%	7.9%		11.1%	8.1%	-3.0%
	Outpatients - 1st to FUP Ratio	2.4	2.3	2.3	1.9	2.0	1.7	2.6	2.4	2.4	2.4	2.3	2.2		2.1	2.4	0.2
	Theatres - Ave Cases Per Hour	2.3	2.2	2.3	1.7	1.9	2.2	2.4	2.5	2.4	2.5	2.6	2.4		2.9	2.4	-0.4
	Theatres - Utilisation of Sessions	82%	82%	82%	80%	85%	90%	85%	82%	79%	85%	82%	79%		85%	82%	-3%
	Theatres - Ave Late Start (mins)	19	17	16	17	17	15	21	20	24	28	27	29		27	25	-1.9
	Theatres - Ave Early Finishes (mins)	41	43	48	59	27	41	33	36	32	33	31	32		39	33	-6.4

Sustainable Services

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

East and North Hertfordshire NHS Trust

Activity Measures	2020-21 YTD	2021-22 YTD	Change
Emergency Department Attendances	61,438	89,599	28,161
Emergency Department Ave Daily Atts	336	490	154
Admission Rate from ED %	23.2%	22.1%	-1%
Non Elective Inpatient Spells	17,936	19,699	1,763
Ave Daily Non Elective Spells	98	108	10
Daycase Spells	10,603	20,625	10,022
Elective Inpatient Spells	1,643	2,594	951
Ave Daily Planned Spells	67	127	60
Day Case Rate	87%	89%	2%
Adult & Paeds Critical Care Bed Days	6,421	6,942	521
Outpatient First Attendances	43,959	48,531	4,572
Outpatient Follow Up Attendances	96,841	115,051	18,210
Outpatient First to Follow Up Ratio	2.2	2.4	0.2
Outpatient Procedures	21,594	43,723	22,129
Ave Daily Outpatient Attendances	887	1,133	245

Workforce Measures	2020-21 YTD	2021-22 YTD	Change
Average Monthly WTE's Utilised	6,044	6,268	224
Average YTD Pay Cost per WTE	25,569	26,393	3.2%
Staff Turnover	12.8%	8.2%	-4.6%
Vacancy WTE's	740	776	36
Vacancy Rate	11.9%	11.9%	0.0%
Sickness Days Lost	48,049	48,161	112
Sickness Rate	4.7%	4.5%	-0.2%
Agency Spend- £m's	4.9	5.4	0.5
Temp Spend as % of Pay Costs	3.2%	3.3%	0.1%
Ave Monthlty Consultant WTE's Worked	345.6	345.1	-0.5
Consultant : Junior Training Doctor Ratio	1 : 1.7	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,477.4	2,667.1	189.7
Qual ; Unqualified Staff Ratio	25 : 10	26 : 10	0.0
Ave Monthly A&C and Senior Managers WTE's	1,333	1,357	24
A&C and Senior Managers % of Total WTE's	22.1%	21.7%	-0.4%

Sustainable Services

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

East and North Hertfordshire NHS Trust

Capacity Measures	2020-21 YTD	2021-22 YTD	Change
Non Elective LoS	3.9	4.3	0.5
Elective LoS	2.4	2.6	0.2
Occupied Bed Days	102,605	91,327	-11,278
Adult Critical Care Bed Days	3,632	3,881	249
Paediatric Critical Care Bed Days	2,789	3,061	272
Outpatient DNA Rate	7%	8%	0.6%
Outpatient Utilisation Rate	32%	44%	12.3%
Total Cancellations	58,728	58,109	-619
Theatres - Ave Cases per Hour	1.6	2.4	0.8
Theatres - Ave Session Utilisation	74%	82%	8.6%
Theatres - Ave Late Start (mins)	26	25	-1
Theatres - Ave Early Finishes (mins)	35.7	33.0	-3
Radiology Examinations	154,913	198,057	43,144
Drug Expenditure (excl HCD & ENH Pharma) - £000s	4,184	5,413	1,229
High Cost Drug Expenditure - £000s	22,135	25,875	3,741

Finance & Quality Measures	2020-21 YTD	2021-22 YTD	Change
Profitability - £000s	25	205	179.5
Monthly SLA Income £000s	36,134	37,454	1,320
Monthly Clinical Income per Consultant WTE	£104,548	£108,535	£3,987
High Cost Drug Spend per Consultant WTE	£64,042	£74,981	£10,939
Average Income per Elective Spell	£1,134	£1,188	£54
Average Income per Non Elective Spell	£2,291	£2,760	£470
Average Income per ED attendance	£177	£183	£6
Average Income per Outpatient Attendance	£130	£142	£12
Ave NEL Coding Depth per Spell	7.4	7.9	0.5
Procedures Not Carried Out	1,196	1,031	-165
Best Practice HRGs (% of all Spells)	4.6%	3.0%	-1.6%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Jun-21	9,415	9,285	-130
Non-elective re-admissions within 30 days % Rolling 12-months to Jun-21	8.52%	8.66%	0.14%
SLA Contract Fines - £000's	0	0	0

East and North Hertfordshire NHS Trust

Agenda item: 10

TRUST BOARD - PUBLIC SESSION – 03.01.2021

Addressing ambulance handover delays

Purpose of report and executive summary (250 words max): The Trust has been requested by NHSE/I to review delays in handing over responsibility for the care of patients from ambulances to emergency departments. The Trust has been asked specifically to determine actions to eliminate handover delays with immediate effect. The Trust is also required to: • Report the actions taken to ensure delays have been eliminated in all Board meetings • Discuss, in a Board meeting, the challenges with data to support the issue (inviting clinical staff from the relevant areas to join the discussion if helpful). • Urgently have a conversation with our Regional Director to review the actions we may need to take and agree an action plan. This paper sets out the requirements from NHSE/I, options to address them, timescales for implementation, risks and next steps.		
Action required: For discussion		
Previously considered by: N/A		
Director: **Chief Operating Officer**	**Presented by:** **Chief Operating Officer**	**Author:** **Senior Operations Advisor**

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

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

Addressing ambulance handover delays

Introduction

1. The Trust was asked by NHSE/I, on 27 October, to review and address delays in handing over responsibility for the care of patients from ambulances to emergency departments (see Appendix A, attached separately).

2. Specifically, we have been asked to:

    a) take action to ensure that:
        - ambulances are not used as additional ED cubicles.
        - crews are able to safely offload their patient to the care of the ED.
    b) work together as a system to agree what actions would be required to immediately stop all delays.
    c) report, in all Board meetings, the actions taken to ensure delays have been eliminated.
    d) discuss, in a Board meeting, the challenges with data to support the issue (inviting clinical staff from the relevant areas to join the discussion if helpful).
    e) meet with Ann Radmore, Regional Director in the w/c 1 November (NHSE/I to arrange) to:
        - discuss the actions we will be taking to eliminate delays.
        - agree an action plan for the system.

3. This paper describes our initial options appraisal and a proposed approach to reducing and stopping delays. This is a very challenging ask. It is important that it is regarded not only as a ENHT issue to resolve but one that system partners need to work together to address. Every part of the pathway from the community, to the hospital and back to the community can cause delays and bottlenecks and so a collective response is required.

4. This paper sets out our initial thoughts following receipt of the NHSE/I letter last week. Work is ongoing both internally and with system partners to consider further options and approaches.

5. The NHSE/I letter emphasises that corridor care is unacceptable as a solution. It should be noted that this is not something we do at ENHT.

Background

6. Appendix B provides more detail around ambulance handover times. The current data around handover times is as follows:

    - On some days we can have over 10 ambulances waiting at any one time.
    - Over the last 14 days the average handover time ranged from 24 to 78 minutes. Maximum handover times ranged from 54 to 321 minutes.

- In September 2021, 783 patients waited over 30 minutes in an ambulance before being handed over. 336 patients waited over 60 minutes. The figures are similar each month, although it should be noted that our temporary ambulance handover area (in place while building work is taking place) adds around 5 minutes to current handover times.

Options

7. We have considered a range of options, as follows:

	Options proposed in NHSE/I letter	Implications/ risks
1	Establish surge capacity/ priority admission unit to care for patients out with ED following a decision to admit; this may require conversion of existing space, or temporary accommodation, within the acute trust to accommodate patients prior to admission to the appropriate ward	Options considered • It might be possible to implement this for patients identified for admission who have already been seen, clerked and are stable. These patients could be moved to a different area to wait. • It may be possible to utilise the discharge lounge as an admissions unit for patients confirmed for admission to a ward (subject to further consideration). The process for this would require patients confirmed for admission to be transferred to the discharge lounge to wait at the point where a bed has been confirmed. A team (consisting of a nurse, porter and cleaner) would work together to move the inpatient from the ward to the discharge lounge, clean the bay and transfer the new patient from the discharge lounge to the ward. Further work will take place internally to work this plan up to implementation. • It may be possible to expand our existing space, however options are limited for the creation of a new area. Using the discharge lounge as an admissions unit would create some additional capacity. Conclusion/ next steps • Proceed with discussions to use the discharge lounge as an admissions unit. • As part of our ongoing work we need to consider the following: o Can we create a bigger assessment area? o Do we have the staffing to support another space? o Would using the discharge lounge in this way impact on discharges? Strict protocols would need to be in place to prevent issues. o What are the implications for infection, prevention and control (including in relation to Covid). o At what point can the wards start reverse boarding. What are the trigger points for this?
2	Wherever practical implement “fit-to-sit” for patients that do not require a trolley	• This is already in place at ENHT. Conclusion/ next steps • There are some potential improvements we could make by adding more chairs. However this would reduce the capacity for cubicles and is not our preferred option.
3	Ensure early access to clinical decision-makers to enable prompt admission / discharge	Options considered • This already happens within the department, from midday through to early evening. • Improvements could be made by having an additional decision maker available after 5pm. This would increase

	Options proposed in NHSE/I letter	Implications/ risks
		capacity for the service. Similarly if we could increase our Band 7s to cover assessments 24/7, it would support flow out, ensuring patients are ready to leave, in turn increasing capacity for those coming in. Additional Band 7 cover would improve senior leadership and decision making and would have a significant and positive impact on the running of the department. • An additional senior decision maker has been approved as part of winter initiative funding and will be implemented soon. • It would also be appropriate to consider response times from across the Trust if departments are asked to assess patients to identify potential for improvement. <u>Conclusion/ next steps</u> • Once in place the addition decision maker should improve response times to ED. The next step is to proceed with the appointment of this person.
4	Establish additional community capacity to enable earlier discharge for patients no longer requiring acute medical care	• This is a really important point and would significantly improve flow for medically optimised patients. We are keen to work with community partners to develop this. <u>Conclusion/ next steps</u> • Further work to be undertaken with community partners to explore additional community capacity.
5	Increase capacity of discharge lounge to free beds earlier in the day, accompanied by rapid support from non-emergency patient transport services	<u>Options considered</u> • It may be possible to send patients waiting for transport to the discharge lounge. We often have patients waiting for transport early in the day. We need to identify, at 5pm, patients who are not going to be able to leave the Trust. Could they be bedded in the discharge lounge overnight? Further consideration is required and strict criteria/ risk assessments around which patients could and could not go there would need to be developed. • As part of our ongoing work we need to consider the following: o Extending the hours for the discharge lounge to capture those waiting for transport. This would require additional staffing. o Sending patients to the discharge lounge to wait as soon as it opens in the morning if hours remain as they are now. <u>Conclusion/ next steps</u> • Undertake further work to explore increased usage times for the discharge lounge.
6	Maximise discharge through following principles within the hospital discharge and community support: policy and operating model	• We are keen to work with community partners to develop discharge capacity. <u>Conclusion/ next steps</u> • Further work to be undertaken with community partners to explore additional community capacity.
7	Increase direct access to GP streaming, SDEC, acute frailty services and medical / surgical assessment units from ambulance crews to reduce direct ED conveyance	<u>Options considered</u> • We are exploring a range of pathways that might be appropriate for direct access to GP streaming, SDEC, acute frailty services and medical / surgical assessment units. • This includes exploring pathways to enable ambulance services to have direct access to SDEC to avoid ED attendance. Current focus is on the following areas: o Falls without injury

	Options proposed in NHSE/I letter	Implications/ risks
		○ Cellulitis ○ Community Acquired Pneumonia ○ Pulmonary Embolism ○ Deep Vein Thrombosis ○ Chest Pain ○ Shortness of breath (COPD, Heart failure, Asthma) ○ Early pregnancy bleeding ○ Palpitations ○ Atrial Fibrillation ○ Acute headache • It would be necessary to establish red/green areas – and think about staffing implications. • Access to 'Siren' (ambulance data system) would help the ED department because it would enable ED staff to see who is coming into the Trust and plan accordingly. <u>Conclusion/ next steps</u> • Continue work with the CCG to explore pathways appropriate for direct access to GP streaming.
8	Match community and mental health service capacity and demand to enable reduced conveyance to ED for appropriate patients	<u>Options considered</u> • The Trust would like to work with HPFT to identify additional capacity for mental health frequent attenders. Mental health patients currently wait in cubicles in ED for a number of hours and this has implications on the capacity of the department. We would like to be able to divert some mental health patients away from ED to a more appropriate alternative setting. <u>Conclusion/ next steps</u> • Work with HPFT to explore potential additional support for mental health patients.
9	Work with two-hour community crisis response teams to offer appropriate alternative pathways to an ambulance response	<u>Conclusion/ next steps</u> • Work with HPFT and community partners to explore potential additional support for mental health patients.
10	Local agreement of staffing models e.g. using acute trust, ambulance service and community service staff in partnership to support surge capacity	<u>Options considered</u> • The Trust already cohorts patients in order to safely release ambulance crew and increasing the use of cohorting could result in improved ambulance handover times. • Majors 4 is used at the current time (but after winter, as part of the new build, will be repurposed). • In additional, CT is used from 5pm to 7am, for 3 patients. • The new ambulance handover area is due to come online in the next few weeks. There are ambulance handover bays where we may be able to bring in up to 6 patients (subject to risk assessment/ infection, prevention and control rules). There is also a room for clinical incidents that could be used. • As part of our ongoing work we need to consider the following: ○ Can we increase our cohorting capacity? ○ Would the ambulance service have staff to support additional cohorting space? ○ Could EEAST to used to provide some emergency care assistance? Is there scope for a more joined up approach to staffing between the Trust and ambulance Trust?

	Options proposed in NHSE/I letter	Implications/ risks
		Conclusion/ next steps • Work up the use of the new ambulance handover area for cohorting an additional 6 patients.
11	Making use of HALO staff to support handover of care, or working with ambulance services to explore whether Community First Responders are available to take on additional roles to support care for patients	• The Trust already has a HALO working in ED. This arrangement is working well.
12	Work with Provider Collaboratives and ambulance services to support boundary changes and diverts, where this will help to decompress a site	• This is already in place and we will continue to support this.

Other options considered

	Options considered	Implications/ risks
13	Scope to have additional temporary capacity, for example using a porta cabin?	• The Trust is aware that Addenbrooke's hospital is using additional temporary capacity as a waiting area for patients. • ENHT could consider a similar approach, subject to staffing capacity and appropriate risk assessment (including in relation to Covid). Conclusion/ next steps • Determine whether the use of additional temporary capacity (e.g. a porta cabin) would be feasible at ENHT.
14	Use of other areas within the Trust e.g. CAU	• Other areas such as CAU would provide capacity but would be too far from ED to operate safely. Conclusion/ next steps • Not for further consideration.

Preferred options and timescale for implementation

8. Having considered the different options, our preferred options are as follows:

a) Increase cohorting, using the new ambulance handover space when available. Plan the staffing, undertake the required planning and risk assessments to ensure that the department can be used as soon as it becomes available.

b) Consider the option of additional temporary capacity in the carpark for ED patients waiting to be assessed. Determine the costs, staffing requirements and potential risks and issues of this approach. This would be a temporary solution and is the only option that does not interfere with clinical activity space. The location of the additional capacity is important and would need to be close enough to ED for emergency response when needed.

Risks

9. Further work is required for the options proposed and as part of this, risks and mitigations will be considered in detail. Risks include the following:

- Staffing levels; in particular, do we have sufficient staff to support the opening/ use of additional areas.
- Infection, prevention and control requirements including in relation to Covid.
- Timescales for the new handover space/ confirmation of the date of availability

Recommendation

10. Members of the Board are asked to:

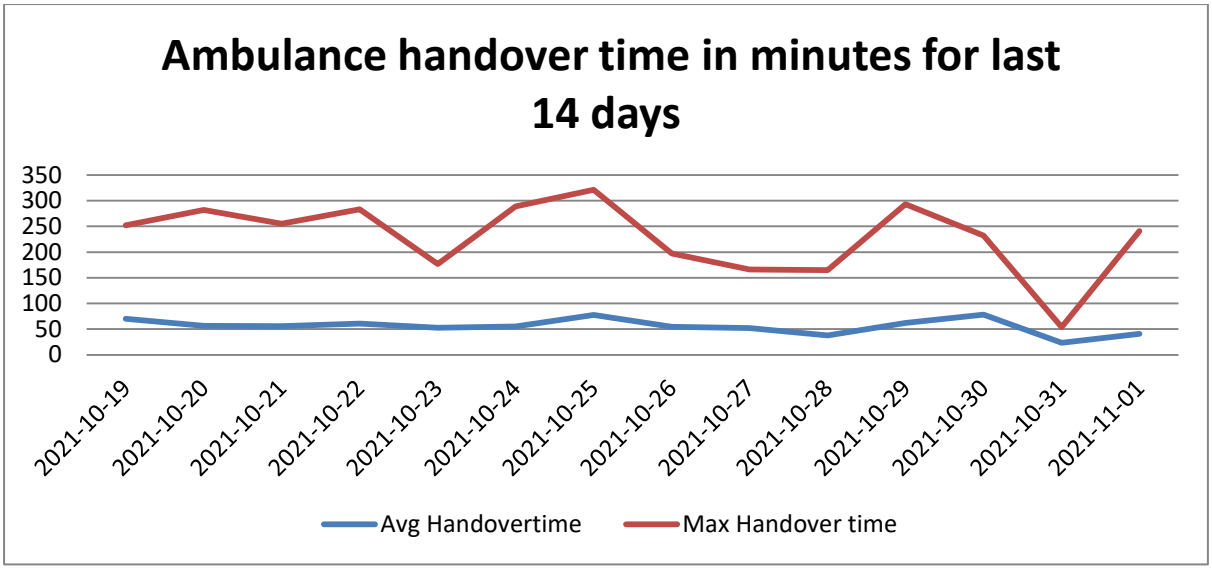
a) Note the options presented.
b) Note the preferred options and support the proposal to work up and implement these options.
c) Note that ENHT will meet with Ann Radmore, Regional Director, on 3 November 2021.
d) Note that updates on ambulance handover performance and progress against improvements will be reported through to FPPC as part of the responsive section in the IPR.

Appendix A: Letter from NHSE/I: Addressing ambulance handover delays

This is attached separately.

Appendix B: Ambulance handover data

1) Ambulance handover time in minutes for last 14 days



2) Ambulance handover breaches over 30 and 60 minutes

HANDOVER BREACHES	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Ambulance handover breaches 30 minutes	215	360	453	458	274	394
Ambulance handover breaches 60-minutes	38	62	119	128	69	73

HANDOVER BREACHES	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Ambulance handover breaches 30 minutes	316	235	76	242	285	317
Ambulance handover breaches 60-minutes	38	10	2	10	19	24

HANDOVER BREACHES	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Ambulance handover breaches 30 minutes	350	507	634	467	327	274
Ambulance handover breaches 60-minutes	64	142	265	144	85	44

HANDOVER BREACHES	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Ambulance handover breaches 30 minutes	380	341	586	548	812	783
Ambulance handover breaches 60-minutes	117	81	194	218	334	336

On average, an additional 5 minutes is added to handover times at present due to our temporary offload location.

Classification: Official
Publication approval reference: BW1101

To: ICS Leads
Acute Trust Chief Executives
Ambulance Service Chief Executives
Acute Trust Chairs

CC: CCG Accountable Officers

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

26 October 2021

Dear colleague,

For action – Addressing ambulance handover delays

We are writing to all Trusts and ICSs regarding delays in handing over responsibility for the care of patients from ambulances to Emergency Departments, recognising that these delays can only be addressed through good system working and cross-organisational cooperation.

In the UEC Recovery 10 Point Action Plan we asked that ICSs "make sure there are robust steps in place to avoid handover delays". We know, and are grateful, that staff within your system are already working incredibly hard to resolve this problem. Given the impact on patients, we must however press to identify further solutions to eliminate all handover delays.

Handover delays

National policy has set out that handovers should take no more than 15 minutes, ensuring patients receive necessary emergency care and allowing ambulances to get back on the road responding to patients in the community.

You will be keenly aware of the risks associated with hospital handover delays.

Acute trusts should take responsibility for patients from when the ambulance arrives and ED staff are informed of arrival, regardless of the patient's exact location. In practice, there is a need for close cooperation and risk sharing between services.

Taking action to eliminate delays

All systems must take action to ensure that ambulances are not used as additional ED cubicles, and that crews are able to safely offload their patient to the care of the ED. It is important that patient safety is prioritised and as a result we emphasise that corridor care is unacceptable as a solution.

We are now asking you to work together as a system and agree what actions you would need to take to immediately stop all delays. We appreciate that this may involve some difficult choices, and that we will need to discuss and involve colleagues, including the CQC, where helpful. For ease of reference we are attaching a list of measures which we know that some of you have implemented which have demonstrated clear benefits.

Today we also are asking Trusts, and their Systems, to report the actions that they have put in place to ensure delays have been eliminated in all Board Meetings, taking time to discuss the challenges with data to support the issue. You may find it helpful to invite clinical staff from the relevant areas to join these discussions.

In addition to the above, because of the significant problems being experienced on the Lister Hospital site, we need to ask that you urgently have a conversation with your Regional Director to review the actions you may need to take to eliminate these delays. We appreciate that this is not an easy ask, as referred to above some of these actions may have implications and we may need to have a dialogue in order to find the best way forward. We anticipate that these conversations should take place w/c 1 November and will result in an agreed plan for the system.

This should not deter you from continuing to taking action to address immediate delays prior to this date.

Initiatives being used in systems

The following is not exhaustive, and a combination of initiatives is likely to be most effective:

- Establish surge capacity / priority admission unit to care for patients out with ED following a decision to admit; this may require conversion of existing space, or temporary accommodation, within the acute trust to accommodate patients prior to admission to the appropriate ward
- Wherever practical implement "fit-to-sit" for patients that do not require a trolley
- Ensure early access to clinical decision-makers to enable prompt admission / discharge
- Establish additional community capacity to enable earlier discharge for patients no longer requiring acute medical care
- Increase capacity of discharge lounge to free beds earlier in the day, accompanied by rapid support from non-emergency patient transport services
- Maximise discharge through following principles within the hospital discharge and community support: policy and operating model
- Increase direct access to GP streaming, SDEC, acute frailty services and medical / surgical assessment units from ambulance crews to reduce direct ED conveyance
- Match community and mental health service capacity and demand to enable reduced conveyance to ED for appropriate patients
- Work with two-hour community crisis response teams to offer appropriate alternative pathways to an ambulance response
- Local agreement of staffing models e.g. using acute trust, ambulance service and community service staff in partnership to support surge capacity
- Making use of HALO staff to support handover of care, or working with ambulance services to explore whether Community First Responders are available to take on additional roles to support care for patients
- Work with Provider Collaboratives and ambulance services to support boundary changes and diverts, where this will help to decompress a site

We thank you for taking this necessary rapid action to address the risks associated with handover delays.

Yours sincerely,

Pauline Philip DBE
National Director for Emergency and Elective Care

Professor Steve Powis
National Medical Director

Ann Radmore
Regional Director

East and North Hertfordshire NHS Trust

Agenda Item: 11

TRUST BOARD - PUBLIC SESSION – 3rd November 2021
System Collaboration

Purpose of report and executive summary (250 words max): This paper sets out for Board members a summary of key strands of system and placed based activities that the Trust is presently participating in.		
Action required: For approval		
Previously considered by: **N/A**		
Director: **Deputy CEO**	**Presented by:** **Deputy CEO**	**Author:** **Deputy CEO**

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): **N/A**

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

East & North Herts NHS Trust

System Collaboration Activity Report

Whilst not an exhaustive list of all system and place based collaborative workstreams that the Trust is presently engaged in; this reports provides updates to board members in respect of key strands of significant activity that the Trust is actively participating in.

System Governance Design & Reform

As the ICS works towards transitioning into statutory body status in April 2022, it has initiated five task and finish groups to inform and shape the structure and nature of future system and place working and arrangements. These groups encompass

1) governance arrangements,
2) target operating model arrangements
3) provider collaborative arrangements
4) validation of system priorities and objectives and finally
5) organisational development proposals.

The Trust has been represented at the meetings of each of these groups by a variety of Executive Directors. Where relevant and appropriate specific issues of escalation and decision making have been referred to both the Executive Directors Committee and also Board Development sessions for discussion and agreement.

System Oversight & Assurance Group (SOAG)

Operational planning guidance for 21/22 sets out the requirements for all ICSs to work in partnership with NHSE/I to take collective responsibility for the management of system resources and performance. It is expected that 21/22 represents a shadow year to ensure that oversight arrangements are in place at ICS, HCP and organisation level. This includes the implementation of regular SOAG meetings. During the course of August and October this bimonthly forum has been established and its Terms of Reference agreed. The Trust has been represented by the CEO / DCEO at this forum. Performance issues discussed and escalated through the SOAG will be highlighted to the ENHT Board through this report in subsequent months. Proposals to extend the review of appropriate performance discussions to a place level (POAG) are also being discussed.

Place Based Engagement Events

To support the development of strong and effective place-based working and collaboration arrangements, an evening engagement event involving key executive and clinical leaders was held on the 27th of September. The event focused upon progressing streams of activity to enhance and reinforce the foundations of joint working across partners. It is intended that these events become a regular feature of strong place-based leadership arrangements going forward. A further event is intended prior to the conclusion of this calendar year and is likely to focus upon how collaboration across winter schemes can provide additional resilience to services during a challenging period.

Enhanced Services Steering Group
During the course of the COVID pandemic a number of new and innovate approaches have been developed or extended in order to help prevent unnecessary admissions into an acute setting or expedite prompt discharge, these include Prevention of Admissions (POA) schemes, Virtual Hospital and Discharge Home to Assess (DH2A)

However, during the course of 21/22 it has become apparent to partners across the place system that there was no jointly designed and aligned framework to determine the impact of these schemes in respect of activity, flow, finance and workforce. It was acknowledged that this presented an impediment to future planning, design and mobilisation arrangements unless addressed. ENHT has therefore taken a lead role in setting up the 'Enhanced Services Steering Group'. This group led by the ENHT Director of Improvement and compromised of Executive Directors across the place ecosystem meets on a bi-weekly basis to progress joint evaluation, design and implementation arrangements. Work to date has focused upon POA evaluation, and has resulted in a jointly agreed impact statement.

ENHT / HCT partnership working projects
The two providers have initiated project working arrangements to explore options to maximise service effectiveness and delivery across areas where the organisations currently deliver different aspects of one overarching pathway.

The two areas that have been identified for accelerated development are Stroke / Neuro services and Community Paediatrics. To date work has concentrated upon creating revised lead provider arrangements as a mechanism to provide greater integration and thereby promoting enhanced quality and delivery outputs.

The group led by Directors of Finance from the two organisations and supported by contracts, operations and clinical staff is working to mobilise the revised lead provider (ENHT) arrangements for Stroke / Neuro during Q3 so that benefits are experienced during the upcoming winter period.

It is anticipated that the work across these services areas can subsequently act as a model for leader provider delivery arrangements to a further pipeline of activity.

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

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

Whilst the finalisation of the model across a five-year period and agreement of funding arrangements is still pending, interim approval has already confirmed the receipt of significant capital and revenue streams to mobilise the model during 21/22.

Martin Armstrong
Deputy Chief Executive
Oct 2021

East and North Hertfordshire NHS Trust

Agenda Item: 12

TRUST BOARD - PUBLIC SESSION – 3 NOVEMBER 2021

A Framework of Quality Assurance for Responsible Officers and Revalidation

Purpose of report and executive summary (250 words max):		
The purpose of this document is to: • Assess effectiveness of medical annual appraisals to support the GMC revalidation requirements. • Ensuring processes and policies are in place to support appraisers and medical appraises achieve the revalidation requirements. • Provide details on actions agreed for 2021/2022 to support the above requirements.		
Action required: For approval		
Previously considered by: QSC – 28.09.21		
Director: Medical Director	**Presented by:** Medical Director	**Author:** Medical Workforce Manager

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): Legal, Quality and Safety, Clinical Governance

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

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019*

**Most recent version*

Contents

Introduction:

The Board Report template now includes the qualitative questions previously contained in the Annual Organisational Audit (AOA). These were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) Provide the necessary assurance to the higher-level responsible officer, and

c) Act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The board/executive management team of East & North Herts NHS Trust can confirm that:

1. ***The Annual Organisational Audit (AOA) for last year was not submitted as Trusts were given the choice whether to submit an AOA or not, in light of covid-19 pandemic.***

Date of AOA submission: September 2021

The data was last submitted in 2019-2020. The 2020-2021 data was not submitted, as last year was a voluntary process in light of the suspension of appraisal related activity for NHS England from 19th March 2020 due to the anticipated impact of the pandemic.

The flexible restart of appraisals from 1st October was announced nationally on 2nd September 2020. The Higher-Level Responsible Officer for the Region indicated that 1st November was a realistic target to allow appropriate appraiser training and notification for doctors. However the Trust took the decision to reinstate appraisal activity from 1st July and later suspended during January & February 2020.

The 20/21 AOA submission is therefore delayed until September this year. Please see details of proposed submission and progress below:

Comments:

There has been an on-going and steady increase in the performance for obtaining, timely qualitative data and completed appraisals for substantive employees using Premier IT and much work has continued for short term employees, as the Medical Advisory Guidance (MAG) GMC process is paper based with no software assistance. From March 2020, due to the covid-19 pandemic, appraisals were stopped and recorded as 'approved missed'. MS Teams has been very successful appraisal enabler since the start of the pandemic.

Completed actions from last year:

- The Lead Appraiser and Revalidation team have worked together now since November 2019 to support the improvement journey and to streamline the end to end appraisal process
- Regards visibility of the numbers and appraisal process for non-consultant grades on fixed term contracts using the MAG form, the year to date has seen a steady increase in completed appraisals, from the previous years for the short term contract holders

Current Issues:

- We need to further reduce the number of appraisals not completed within 3 months of appraisal due date
- Appraisal completion within due date: has improved, reaching approximately 90% however there is still a reduction in the compliance rate due to the on-going COVID-19 pandemic
- There appears to be a rising number of deferrals during Covid, however this should be seen as a positive and appropriate intervention and not as a negative action
- The number of trained appraisers needs to increase and 3 year tenure encouraged
- The contract review for Premier IT is due early 2022, we will consider merits of changing systems/provider, given recent advances in appraisal & revalidation IT Products

Actions taken:

- During the Pandemic the Appraisal and Revalidation team have overhauled all processes and procedures and continue to fine tune quality assurance by introducing an peer review undertaken by Medical Workforce Manager who has recently joined the Trust
- We have supported medical staff with light touch appraisals from March 2020 onwards

- We have aligned the monitoring and reminder schedule for both premier IT and MAG to improve compliance
- We have reviewed and relaunched premier IT reminders on the system and have aligned this process for the MAG manual process
- We have introduced appraisal coaching sessions for overseas doctors who are new to the UK Medical appraisal process

Actions for next year:

- Continue to support medical staff with light touch appraisals
- Develop measureable QA methods to further improve quality
- Continue with the monitoring and reminder schedule for both premier IT and MAG, (aim to increase compliance rates by 5% to 95%)
- Increase the availability of appraisal coaching sessions for overseas doctors who are new to appraisal process
- Review the current rate of deferrals
- The contract review for Premier IT is due early 2022, we will consider merits of changing systems, given recent advances in appraisal & revalidation IT Products we aim to streamline the appraisal process making data collection more efficient and regularly provide quality assurance reports through an integrated system
- Continue to run quarterly user groups, ensuring attendance of at least 1 of 4 groups per year, webinar training refreshers etc.

2. ***An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.***

Completed actions from last year:

- Dr Samita Agarwal was appointed as Lead Appraiser in Nov 2019, she leads medical appraisal activity and user groups, with the support of the appraisal and revalidation team and continues to support the new RO
- A Medical Appraiser job description has been agreed and circulated to all appraisers and discussed during Appraiser training

Comments:

Following the retirement of Dr Nick James (RO between 2017 and 2019-20), Dr Thomas Samuel, Deputy Medical Director and Responsible Officer has now taken over the RO responsibility within the Trust

Actions for next year:

- The current policy is under review, this action was bought forward from last year
- To continue the audit performance process of current appraisers with on-going appropriate training scheduled (delivered 15th September 2021 for a cohort of new Appraisers) and plans in place to support those who are not demonstrating the competences required
- To review of the number of appraisers to appraise quarterly with a focus on QA, we will ensure allocations of appraises do not exceed 6 per year (national guidance is 8 per year)

3. ***The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.***

Completed actions from 19/20:

- Appointment of Lead appraiser appointment in November 2019

Comments:

Following the restructure the team has showed a steady increase in both compliance rates and quality. Performance has been further strengthened with support from the lead appraiser Dr Samita Agarwal (since last November) the team now comprises of one 0.8 WTE Revalidation Officer (dedicated resource), supported by one 0.7 Appraisal Administrator, overseen by Medical Workforce Manager, the Appraisal Lead and Responsible Officer.

Actions for next year:

- Lead appraiser to attend Lead Appraiser regional and national forums and provide an update to all appraisers within the scheduled user groups
- Lead Appraiser and RO to both be appraised by externally sourced Appraisers
- Appraiser user groups should continue for all trained appraisers. Agreed to schedule these quarterly from Oct 2021, sessions will be scheduled for one hour with input from RO and Lead Appraiser

4. ***An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.***

Action from last year: None

Comments:

It is current practice that a monthly prescribed connection list is downloaded from GMC Connect portal which provides an accurate update of revalidation dates and numbers of appraisals required; this informs the monthly appraisal schedule.

New starter correspondence has been introduced which is now emailed out to all employees on commencement at the trust, which includes instructions on how to connect to the trust designated body and the importance of doing this as soon as possible.

A monthly leaver report is reviewed and employees are removed from designated body on GMC connect by the Medical Workforce Manager. This ensures an accurate record of the prescribed connections is maintained.

Actions for next year:

To continue to carefully maintain the starter and leaver process to ensure accuracy of connections to the DB

5. ***All policies in place to support medical revalidation are actively monitored and regularly reviewed.***

Completed actions from last year:

Rolled over to this year, delays were due to COVID-19.

Comments:

Policy review is overdue however underway, existing policy was last updated in 2017. This will reflect the necessary changes introduced by Appraisal 2020

Action for next year:

- A review of current policy by Nov 2021

6. ***A peer review has been undertaken of this organisation's appraisal and revalidation processes.***

Completed actions from last year:

External review, this has been rolled over to next year, however an informal review has been undertaken by the new Medical Workforce Manager during September 2021.

Comments

External review is overdue.

Action for next year:

- Commission an external review from April 2022, when the appraisal process has ran a full cycle and compliance data is available. Seek advice from the Academy of Royal Colleges to determine who is best placed to conduct this review

7. ***A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.***

Completed actions from last year:

- Audit of locum bank/agency appraisal has been actioned and doctors are included in the short term contract holder's process
- Review of GMC MAG process for fixed term employed doctors ensuring compliance

Comments:

We will continue to review short term employees who are employed as temporary bank/agency which come at a cost and agree with the RO/Lead appraiser how these are managed

Actions for next year:

- Continue to deliver introduction of appraisal coaching sessions for overseas doctors who are new to the UK Medical appraisal process
- Create an Appraisal Resource to offer initial guidance to support overseas Doctors better understand the process this will complement and shorten the Coaching sessions allowing for a greater volume of coaching sessions to be delivered
- We have identified that we do not hold an accurate list of all medical honorary contract holders/or those with other Trusts via SLA's and these are not always recorded on ESR. We need to better utilise job planning information and work with the resourcing team to ensure accurate records are maintained and reviewed and where appropriate to ensure all attached to us as a DB are supported with an appraisal and revalidation service

Section 2 – Effective Appraisal

1. ***All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.***

Completed actions from last year:

Carried forward from last year

Comments: The current checklist reviews the scope of practice which includes references to verify the doctor's fitness to practice for all their scope of practice. These are reviewed by the RO when appraisals are due for revalidation.

Actions for next year:

• A monthly report request sent to complaints and Incidents to obtain a report for doctors who have been directly involved in incidents and complaints.

• Monthly audit of appraiser output forms, identifying training needs with feedback to the individual appraiser and updates provided during scheduled user groups.

• Commence the analysis of appraise feedback of the appraisal process for permanent doctors in Premier It.

• Ensure staff have access to monthly reports on complaints and incidents, allowing them to discuss during scheduled appraisals and submit reflection. Discussions with Medical Directors office to use Datix cloud which may help facilitate this

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

Completed actions from last year:

This has been rolled over to next year.

Comments:

Current policy is complaint, approved and ratified by JLNC in 2017

Action for next year:

- A review of the policy is scheduled with completion date Nov 2021, ensuring the trust complies with national changes. The policy will be reviewed by the board and ratified by the JLNC.

3. ***The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.***

Completed actions from last year:

- Following a review of prescribed connections and number of trained appraiser for the trust, additional appraisers were recruited in June 2019, January 2020 and September 2021.
- The reason was to limit allocations to a maximum of 6 appraises per appraiser, in line with the appraiser job description.

Comments:

The number if appraisers against the prescribed connections for the trust are still too low. The allocations require further review to ensure a far distribution of Premier IT and MAG appraisal are undertaken.

Action for next year:

- Continue to review the ratio of appraises to appraiser
- Review number of allocations across appraisers (x6 per annum)
- Continue and schedule user groups and increase session to quarterly next Group Oct 2021 with updates from RO and Lead Appraiser
- Quality assurance of appraisers and identify training and development activities

4. ***Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).***

Completed actions from last year:

Part actioned and brought forward for implementation 21/22

Comments:

We are developing and soon to implement a feedback process which is actioned through premier IT, whereby a feedback request is automatically generated and emailed to each Appraise following their Appraisal. This request for feedback on the Appraisal is automatically submitted and returned to the Appraiser (responses are then collated and reviewed by the Revalidation Officer). We are also developing a QA check list to use to review the quality of each appraisal undertaken. This audit exercise will be carried out by the Medical Workforce Manager, Lead Appraiser/RO to review appraisal quality undertaken for both Premier IT & MAG systems. This will be fed back individually and common themes discussed at user group meetings.

Action for next year:

- Audit of appraises feedback on appraisals undertaken on Premier IT and align a similar process for the MAG process. Identify training and development activities to take to user groups
- Continue quarterly user groups with workshops where required
- Introduce monthly appraiser update communications following any local or national updates
- Fine tune the appraiser and revalidation folder on the knowledge centre. Upload user group material i.e. policy, guidance, presentations, meeting notes and any national guidance
- Appraisal Lead to embed the mentorship/buddying programme of new appraisers with high performing appraisers

5. ***The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.***

Completed actions from last year:

Bought forward from last year

Comments:

Following attendance to regional network meetings, the Lead Appraiser with the Medical Workforce Manager to agree a robust QA process to ensure appraisal are conducted to meet GMC guidance.

Action for next year:

- Currently further developing a quality assurance process by the end of 2021, which will include feedback and further training where required to all appraisers

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Section 3 – Recommendations to the GMC

1. ***Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.***

Completed actions from last year:

Bought forward from last year

Comments:

Current Process is all fitness to practice cases are discussed the Decision Making Group (DMG) and where necessary NCAS are consulted. The DMG consists of:

1. Deputy Medical Director & Responsible Officer, Senior Medical Workforce Lead

Action for next year:

Bought forward - Review of the current Conduct, Performance and Ill-Health Procedures for Medical and Dental Staff to ensure the trust is maintaining compliance with the national procedures and RO regulations

2. ***Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.***

Completed actions from last year:

- Revalidations files are all reviewed by the appraisal and revalidation team and issues highlighted to Responsible Officer ahead of the submission date
- Positive recommendations are confirmed by email to a doctor and the GMC also send out this communication
- Doctors are contacted by the RO if a deferral or non-engagement recommendation is going to be made

Comments:

Changes made to revalidation in response to the coronavirus (COVID-19) pandemic resulted in 134 doctors who were due to revalidate between 17 March 2020 and 16 March 2021, had their revalidation submission dates moved back by one year

To accommodate flexibility in making recommendations, all these doctors were put under notice by the GMC. This means that responsible officers can submit recommendations to revalidate those doctors at any time up to their new submission date.

Following this decision and to manage the revalidation workflow in the following year, it was agreed to contact those doctors with original due dates from April to the end of September 2020 to give them the 2 options:

a, adhere to their new moved revalidation submission date in 2021, or

b, stay with the original 2020 revalidation submission date to be retained when documentary evidence is ready

The team also wrote the remaining with submissions dates in October 2020 to March 2021 giving them the same options above.

Action for next year:

- The team continue to support doctors to achieve the key elements to achieve a positive revalidation recommendation

Section 4 – Medical Governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Completed actions from last year:

Nil

Actions continued from last year:

- No changes since last report; no concerns. Workforce continue to follow the SOP for ESR Gap Analysis and Audit SOP to ensure the information entered about employment checks on ESR for all new starters s accurate
- Quality and completeness of data entry will be checked on a monthly basis and analysed for gaps by the workforce governance team

Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal

1. ***There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.***

Completed actions from last year:

Carried forward from last year

Comments:

Established process and policies in place that support concerns raised.

Action for next year: Carried forward from last year.

Ensure revised Conduct, Performance and Ill health Procedures for M&D staff policy is agreed and ratified by the LNC.

Revised appraisal policies to be agreed and ratified by Nov 2021

2. ***The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].***

Completed actions from last year:

Nil

Comments:

All the concerns are discussed in the DMG. A full analysis has not taken place over the past year due to COVID 19

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Action for next year:

Full analysis to take place in the next financial year

3. ***There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].***

Completed actions from last year:

Nil

Comment:

MPIT or transfer of Information (TOI) forms are used to obtain information on doctors working between hospitals. These forms require approval by the RO. This responsibility now sits within the Appraisal & Revalidation team and applied following appointment however further enquiry and discussion is required to determine whether this process should and could be part of pre-employment checks.

On receipt of an enquiry the revalidation and appraisal team request data from the appropriate departments, i.e. if there has been any complaints, incidents or claims relating to the doctor. Once received the form is completed and forwarded to the RO to review and approval sought. This is currently in addition to the referencing (recruitment pre-employment checks)

Action for next year:

- Continue and review current process

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

Comments:

Currently Multi Organisational Working Reference (MOWR) is issued by the team from doctors practising privileges as recorded in the Scope of Practice identified on the their last appraisal before revalidation.

Medical Workforce Lead and ERAS, sit on the Decision Making Group, the most effective quorate of this group needs to be established

Action for next year:

- Review whether MOW references or a Medical Practice Information Transfer Form should be uploaded as supporting information evidence on yearly appraisals
- Discuss further with Lead Appraiser/RO to introduce from Oct 21
- Review Conduct, Performance and Ill-Health Procedures for Medical and Dental Staff has been in line with national procedures and route to be ratified by the LNC
- Continue monthly Decision Making Group meetings to discuss concerns raised are timely

Section 5 – Employment Checks

1. ***A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have***

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Comments:

- Medical Workforce team undertake appropriate pre-employments checks which include references for all permanent and fixed term contract holders. These records are maintained on TRAC
- The temporary staffing team administer checks for the bank trust locums and liaise with agencies for agency staff to ensure compliance
- Workforce governance monitor ESR records, undertaking a gap analysis of all new starters to ensure all appropriate records are completed and compliance is monitored.

Action for next year:

1. Continue with the above

Section 6 – Summary of comments, and overall conclusion

All revalidations that would be occurring after 19th March 2020 will be deferred for 12 months.

Please use the Comments Box to detail the following:

General review of last year's actions

Some have been bought forward to next year

Actions still outstanding

- Commission external review
- Update the current Appraisal and Revalidation Policy
- Draft Conduct, performance and Ill-Health Procedures for Medical and Dental Staff for ratification by the LNC.
- Develop robust quality assurance process

New Actions and Overall conclusion:

Policy and Process Review:

- Medical Workforce Manager with Responsible Officer/Lead Appraiser to conduct a review of the policy and seek ratification by the JLNC by Nov 21
- Clarify around non-engagement process
- Further streamline processes in line with the policy so that the administrative team can work efficiently
- Improving the management and compliance rates for appraisals of short term employees by mirroring those processes in place for substantive employees.
- Increase the lead time for recommendations by early review of appraisal and supporting information so that issues are highlighted in advance allowing the RO to discuss with the doctor ahead of making a recommendation and ensure no recommendations made after GMC deadline
- Ensure the draft Conduct, performance and Ill-Health Procedures for Medical and Dental Staff has been reviewed and been ratified by the LNC
- Review quarterly ratio of appraisers to appraise
- Develop and maintain an appraiser and revalidation folder on the knowledge centre Upload user group material i.e. policy, guidance, presentations, meeting notes and any national guidance
- Ensure staff have access to monthly reports on complaints and incidents, allowing them to discuss during scheduled appraisals and submit reflection. Discussions with Medical Directors office to use Datix cloud which may help facilitate this.

Support team improvements:

- Training and support of the revalidation and appraisal team by the head of medical workforce and lead appraiser
- Keep resourcing and performance under review

Quality Assurance:

- Commission and external review once the policy has been ratified and embedded in 2022.
- Undertake appraisal quality audits by reviewing the checklist process by undertaking spot-checks on appraisals for doctors, not under notice in that year
- Trust recognition and feedback for appraisers on their performance; ensure this is reviewed in their own appraisal
- Audit prescribed connections list accuracy to evaluate effectiveness of current processes
- Audit of locum (bank/agency) appraisal and revalidation process

Appraiser Resourcing:

- Increase appraisal user group from bi-annual to quarterly from October 21
- Lead appraiser to consider mentorship/buddying programme of new appraisers with high performing appraisers
- Appraisal lead to review ratio of appraiser to appraise quarterly and recruit and train in accordance

Section 7 – Statement of Compliance:

The Board of East & North Hertfordshire NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

East and North Hertfordshire NHS Trust

Agenda Item: 13.1 a)

TRUST BOARD - PUBLIC SESSION – 3 NOVEMBER 2021

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING HELD ON 29 SEPTEMBER 2021

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present the report from the FPPC meeting on 29 September 2021.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of FPPC	**Presented by:** Chair of FPPC	**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) The discussions at the meetings reflect the BAF risks assigned to the FPPC.
Any other risk issues (quality, safety, financial, HR, legal, equality): N/A

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

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING
29 SEPTEMBER 2021

SUMMARY TO THE TRUST BOARD MEETING HELD ON 3 NOVEMBER 2021

The following Non-Executive Directors were present:
Karen McConnell (Chair), Ellen Schroder (Trust Chair), Biraj Parmar, Jonathan Silver and David Buckle

Stroke Deep Dive
A Stroke Services Deep Dive was presented to the FPPC providing a current performance summary with comparison to the previous quarterly results and the updated action plan aimed at achieving a SNAAP score of A requested by the Committee.

The Committee noted a deterioration in Stroke performance in the month, noting key steps being taken to improve performance.

The four main areas for improvement with actions being taken were presented and it was explained that the SSNAP rating occurs over a three month period and is re-calculated at the end of each three month period. Key outcomes from improvements will be presented at FPPC in February 2022.

Finance Report Month 5
The Director of Finance presented the key points in relation to financial performance for month 5. The Trust is currently reporting against a break-even plan set for April to September 2021. The Trust is reporting a £0.4m surplus year to date.

The Committee was advised of an executive decision to amend the capital funding plan, subject to approval via the appropriate governance process.

The FPPC discussed Trust's approach to the Elective Recovery Fund and how it compares to other organisations within the system, noting the interdependency with the performance of the system partners.

H2 Planning Guidance and Budget
The Committee noted that the H2 planning guidance had not yet been published, preventing the Trust from finalising its H2 plan. A draft budget had been prepared and would be presented to FPPC once the guidance was finalised.

H2 CIP Delivery Plan
The Committee received an update on preparations for and progress to date in relation to the H2 CIP savings, based on a provisional target. Once final guidance is received, the savings target may change. The Committee noted the need for transformational CIP schemes beyond H2 and into 2022/23.

ED Capital Plan
The FPPC received an update on the ED capital plan with an overview of current expenditure. It was reported that construction milestones are being met. The Committee discussed the high level objectives of the build and suggested these be revisited to ensure possible adjustments to the plans were considered at the appropriate time and overall aims of the build were met. An updated report will be presented to FPPC in November 2021.

ED Action Plan
The FPPC were presented with a four point recovery plan which is aligned with the national plan for ED performance. The Committee were advised of an increase in operational pressures in recent months and that the ED have been working with system operational partners as appropriate.

The FPPC were advised of a high level plan to improve performance containing four main actions:

- Reduce non-elective attendances.
- Improve flow.
- Improve discharges.
- Improvements to be made through the ED capital build.

The FPPC noted positive feedback from a recent ECIST visit, thanked the team for presenting the deep dive and looked forward to receiving updates on progress against the high level action plan.

Improvement Plan Update
The FPPC received an update on the Trust's transformation programmes. The Committee was informed the portfolio has taken a more strategic direction and bottom-up approach, with greater engagement with clinical divisions from the outset.

The Committee discussed the virtual ward in particular, in terms of its capacity, usage targets and actions to increase uptake.

Payment Reform Proposals
The Director of Finance presented the summary of the 2022-23 NHS Payment System Reform, highlighting key considerations for the FPPC and Trust. The Director of Finance also highlighted the proposals regarding the ICB Financial Framework. The proposals were noted by the Committee.

Community Diagnostic Hub Bid
The FPPC discussed the work that had taken place in response to the NHSE national programme for Integrated Care Systems to bid for capital and revenue funding over five years to launch community diagnostic hubs. A steering group was established to engage with the wide range of system stakeholders to develop a model for submission to NHSE on how the partnership's diagnostics will help meet the population health needs, operational challenges and requirements set out by NHSE. The bid consisted of a phase one element for year one and a separate bid for more ambitious development of the service in phase two over years two to five. The Committee welcomed the report.

People Report Month 5
The FPPC considered the people report for month 5:

- Vacancy rates remained just above the target level.
- There had been an increase in turnover, primarily due to expected medical staff turnover at this time of year.
- There had been an increase in staff who are 100% compliant on statutory mandatory training.
- Appraisal levels were lower due to the transition to the new system which has involved some data cleansing.

People Team Strategy Update
The FPPC received an update on the delivery of the People Strategy since the last progress report. The report provided an update under each of the four People Strategy Pillars.

Performance Report Month 5
The Committee noted a deterioration in performance against the four hour target and also a deterioration in ambulance handovers, which will be improved by the new ED build and other actions discussed earlier in the meeting.

Cancer performance was performing well against the national position on the whole.

Regarding RTT, plans are in place to reduce the 104 week waiters with various initiatives in place to support keeping the Trust's patients safe while they wait.

Engagement and Staff Experience
The Committee was informed of the progress achieved to date on the staff experience initiatives and future plans. The Committee received updates on the staff survey, the plans to put in place a reciprocal mentoring scheme as part of the equality, diversity and inclusion agenda and the imminent commencement of the flu and Covid booster vaccination programmes.

Board Assurance Framework and Risk Report
The FPPC considered the latest editions of the BAF and Risk Report. In relation to the BAF, there were no proposed changes to risk ratings at this time.

FPPC Evaluation and Review of Terms of Reference
The Committee approved the review and supported the proposed actions and amendments to the Terms of Reference, which will be presented at the next Board meeting for approval.

Vascular Surgery FBC Approval
The FPPC reconvened as the Trust Board to consider the Vascular Surgery Business Case.

_____

Karen McConnell
Finance, Performance and People Committee Chair
September 2021

East and North Hertfordshire NHS Trust

Agenda Item: 13.1 b)

TRUST BOARD - PUBLIC SESSION – 3 NOVEMBER 2021
FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING HELD ON 27 OCTOBER 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present the report from the FPPC meeting on 27 October 2021.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of FPPC	**Presented by:** Chair of FPPC	**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) The discussions at the meetings reflect the BAF risks assigned to the FPPC.
Any other risk issues (quality, safety, financial, HR, legal, equality): N/A

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

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING
27 OCTOBER 2021

SUMMARY TO THE TRUST BOARD MEETING HELD ON 3 NOVEMBER 2021

The following Non-Executive Directors were present:
Karen McConnell (Chair), Ellen Schroder (Trust Chair), Biraj Parmar, and Jonathan Silver

Discharge Improvement Programme
The FPPC were presented with a Discharge Improvement Programme which aims to improve the quality safety and efficiency of the discharge process. The Committee were advised that approximately 20% of patients are medically optimised to be discharged but are still residing in hospital beds. The Committee discussed the reasons for delays in discharging and some of the solutions, including the possible use of non-medical prescribers and an increase in discharge coordinators to improve the time taken to discharge patients.

The Committee noted a pilot scheme initially on ward 10B with later additions of other wards which has worked well and which will be rolled out in other areas, one area at a time. The Committee discussed the changes including cultural changes that would be required to ensure ongoing success of the project. The programme is supported by the Transformation and Quality Improvement Teams. The Committee will follow up the project in the New Year.

Winter Plan
The FPPC considered the winter plan, noting increased activity at the front door starting earlier than usual in the year. Initiatives that were put in place in the previous Covid surges are ready to be deployed when needed. Gold, Silver and Bronze meetings have been stepped up.

The Committee noted initiatives and work with system partners to reduce the amount of patients coming through the front door to reduce demand in ED and improve flow. The Committee also noted a recent increased number of patients waiting to be offloaded from ambulances. Options are being explored as to how patients can be managed prior to reaching ED so as not to overwhelm the department. The FPPC were advised of a continued increase in mental health patients, particularly in younger age groups; this risk had been discussed in the Quality and Safety Meeting.

It was confirmed that data is being used for forward planning to ensure the Trust is well prepared.

Performance Report Month 6
The FPPC considered the key points in relation to operational performance for month 6. ED performance was 69.51%, being the lowest reported against the four hour standard. This reflects the recent challenges in ED with increased attendances and ambulance handovers. An ED action plan is in place to address the main challenges. There were zero 12 hour trolley waits reported in September.

RTT performance remains a challenge with the backlog increasing due to the increase in demand. The Trust is committed to removing the 104 week breaches by the end of the financial year with plans in place to do this, and to stabilise the 52 week breaches. A deep dive is planned by the Committee in November. The Committee noted the work being carried out to improve the SNNAP rating for Stroke. Diagnostics performance for September was 37.01%.

Health and Wellbeing
The FPPC received a presentation on health and wellbeing initiatives. It was confirmed that having an in house occupational health service has had a positive impact in supporting staff members' individual needs. The Committee was informed of the means of accessing support, via an easy to use electronic form for self-referral along with a telephone advice line for more urgent help.

The Committee noted 40 staff have been trained as mental health first aiders with a plan to train further people.

It was reported that ENHT is in the top half of Trusts for staff to have the first and second Covid vaccinations, however the Trust is not performing as well with the booster vaccinations. This is particularly relevant to certain parts of the Trust and will continue to be an area of focus for improvement.

People Report Month 6
The FPPC considered the people report for month 6:

- The vacancy rate remains at 6.3%. The nursing vacancy rate has decreased from 3.6% to 3.2%, with 131 more nurses in post than 12 months ago.
- The Committee were advised statutory training compliance is 88%. The number of staff with 100% compliance has decreased to 57% from 62%.
- The Committee were advised the staff survey completion rate is 30% with 4 weeks remaining.
- The FPPC noted an increase by 0.3% of sickness absence rates.

Temporary Staffing
The FPPC considered Temporary Staffing activity for the period April to September 2021. The Committee noted although the utilisation of agency had recently increased, the agency spend is closely monitored and remains £700k below the agency ceiling spend. The Committee were advised that nursing and midwifery made up 64% of the temporary staffing demand, 22% of which was unqualified staff. The Committee had concerns that the vacancy rate is reasonable at 3% however there have been reports of under staffing in some areas and there was concern that the deployment of staff may not be in the correct areas. There will be a future deep dive on this topic.

Resourcing
The FPPC discussed the Resourcing paper relating to resourcing activities carried out for medical and non-medical staff between May and September 2021. During this time the Trust welcomed 512 new starters and 535 people left the Trust. The staff group with the highest vacancy rate was Clinical Support, equating to 76 vacancies. Despite challenges earlier in 2021 relating to overseas travel and quarantine requirements, 47 international nurses arrived between 1 May and 30 September 2021, with a further 42 international nurses in the pipeline

The Committee discussed turnover levels which has increased from 12.5% to 12.8%, and there will be a future deep dive regarding the reasons for turnover.

Employee Relations
The FPPC noted the Employee Relations report covering the activity of the last 12 months and the next steps for quality improvement.

Finance Report Month 6
The FPPC considered the key points in relation to financial performance for month 6. The Trust is reporting against a break-even plan for April to September 2021. The Trust is reporting a £0.4m surplus at the end of H1. The reported position includes an estimate of income earnt as part of the Elective Recovery Framework (ERF). The fund will continue across H2 and the Committee noted the system wide arrangements relating to the fund.

The Committee were advised of ongoing Covid specific costs being incorporated into BAU budgets for the first half of 2021/22. The H2 planning guidance reduces the Covid systems funding by 25% and this has been built into the Trust's CIP plans for H2.

H2 Planning Guidance and Budget
The FPPC were advised the NHS received confirmation in September that it will be allocated an extra £5.4bn in the next six months. The Committee noted funds have been set aside for winter pressures.

The Committee endorsed the proposed budget for H2.

H2 CIP Delivery Plan
The Committee was presented with the H2 CIP savings progress for 2021/22 with the target set at £7.3m for H2. The Committee discussed the need for transformational changes to achieve savings in 2022/23 and possible opportunities in private patients work.

Population Health Update
The FPPC received an update on the progress made in the past three months in relation to Population Health Management and next steps including identification of areas for detailed insight and targeted intervention.

Board Assurance Framework
The FPPC considered the key risks on the Board Assurance Framework. The Committee discussed risk ratings and agreed to increase the risk relating to operational delivery of core standards from 16 to 20 and decreased the finance risk from 16 to 12.

_____

Karen McConnell
Finance, Performance and People Committee Chair
October 2021

East and North Hertfordshire NHS Trust

Agenda Item: 13.1.1

TRUST BOARD - PUBLIC SESSION – 3 NOVEMBER 2021
FPPC Annual Evaluation and Review of Terms of Reference

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

The findings of the review indicate that the FPPC has met its duties in the period. The review has not identified any significant issues and in fact has found that the Committee responded effectively to the exceptional challenges faced in the last year, taking an agile and proactive approach to providing assurance to the Board and escalating risks where appropriate.

Some recommendations for minor changes for 2021/22 have emerged from the review:

- To continue to strengthen links with other committees, perhaps through implementing a regular meeting between committee chairs,
- To continue to monitor the forward plan regularly throughout the year to ensure that effective balance is maintained between the operational, financial and workforce domains and duplication with other Committees and the Trust Board is avoided,
- To continue to build into the reports and discussions relating to the finance, performance and people domains an appropriate focus on the system collaboration context.

The Committee's Terms of Reference have been reviewed as part of this process and some updates are proposed. These are primarily to reflect changes of duties and responsibilities in response to the creation of the Strategy Committee and Equality and Inclusion Committee. The updated Terms of Reference are attached as Appendix 1.

Action required: For approval

Previously considered by:
FPPC, 29 September 2021

Director:	**Presented by:**	**Author:**
Director of Finance	**Chair of FPPC**	**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):

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

Introduction

The FPPC is a key assurance committee of the Trust Board. As defined by its current Terms of Reference, 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 2020/21, based on analysis of the work of the Committee over the period as evidenced through a review of the minutes and summary reports and also taking into account the feedback received via a survey of Committee members.

Meetings and membership

With the exception of the period at the start of the Covid pandemic, there were no significant changes to the meeting format over 2020-21. In response to the immediate pressures at the start of the pandemic a joint meeting with QSC members was held in April 2020 which also included some QSC agenda items. Following that meeting, the two committees returned to having separate monthly meetings (with the exception of August when no meetings are held).

In terms of membership, Mr Niven was a member of the Committee for the duration of 2020/21 but stood down from the Committee following his appointment to the Equality and Inclusion Committee in May 2021. Any changes to Board personnel are outlined in the Trust's Annual Report 2020-21.

Reporting arrangements

The Chair, supported by the Trust Secretariat, provides a summary report for consideration by the Trust Board after each meeting.

Key duties and responsibilities of the FPPC:

This section of the report explores how the FPPC has met its key duties and responsibilities under its Terms of Reference. It is worth noting at this point that the introduction of the Strategy Committee and Equality and Inclusion Committee in November 2020 and May 2021 respectively has meant that some of the duties and responsibilities that were previously part of the FPPC's remit are now assigned to those committees.

Finance

- As a result of the Covid pandemic, the nature and sequencing of many of the financial reports considered by the Committee deviated from previous years, but this did not stop the Committee from acting as an effective assurance committee in

relation to the Trust's business and finance risks. The Committee was kept appraised of the Trust's approach in terms of recording and reclaiming additional costs incurred in relation to the Covid pandemic, received updates regarding the funding arrangements for the year as NHS England guidance emerged and was kept informed of the 2021/22 budget planning and setting process. The Committee also received good assurance on the steps the Trust was taking in the instances where national guidance was not forthcoming and ensured the Trust remained well placed to respond at the appropriate time.

- The FPPC reviewed and endorsed business cases as required, referring business cases to the Board for final approval where appropriate.
- The FPPC reviewed and approved the Trust's capital plan and, in light of the increased capital funding that became available in response to the Covid pandemic, the FPPC received regular updates on progress against the capital plan up to year end.
- For the period up to the commencement of the Strategy Committee, the FPPC monitored and reviewed a number of the Trust's enabling strategies and in particular their triangulation with financial information.
- On behalf of the Board, the FPPC reviewed the costing assurance submission, ensuring it met the expected requirements.
- The Committee regularly discussed the direction of travel and emerging advice and guidance in relation to system collaboration from a financial perspective.
- The Committee received reports regarding the financial governance framework, which set out the governance arrangements from a divisional level upwards.

<u>Performance</u>

- The FPPC continued to receive at the minimum a monthly update report regarding the Trust's operational performance throughout the period, but recognised that there were periods of extreme operational pressures and flexed the meeting agendas accordingly. As the year progressed, the performance reporting resumed in earnest and the deep dive schedule was refreshed. The FPPC received a monthly Performance Report, which was extracted from the 'Responsive services' section of the IPR. This provided the Committee with data on performance against each of the national performance standards. The impact of the Covid pandemic on the metrics was discussed and monitored. A highlight of the period from an operational perspective was the sustained good performance against the cancer standards.
- Following the pausing of certain services as per the national guidance at various points over the year, the Committee sought assurance regarding the plans to recover services that were being developed and submitted. The plans were based on thorough demand and capacity modelling and triangulated with financial planning in relation to the income incentives for recovery.
- The FPPC paused the deep dive schedule for a period at the outset of the Covid pandemic, but reinstated this in late summer/early autumn 2020. The deep dives concerned a range of services and issues, including stroke, outpatients and theatres performance and the rolling programme has continued into 2021/22.
- The FPPC reviewed the bed plan over the year, in the context of the unprecedented pressures the Trust faced and also received assurance regarding the Trust's winter mobilisation.
- The Committee paid keen attention to the development of the ED capital bid and implementation of the plan, from the perspective of project delivery and considering the short term challenges and longer term benefits to the Trust operationally.

Workforce

- The Committee monitored the implementation of the People Strategy which was approved in the previous year, noting the different context in which it now applied as a result of the impact of the Covid pandemic. As a result, the Committee had an increased focus on the health and wellbeing support available to staff, recognising the extreme pressures they faced at various points in the year.
- Another element of the People Strategy that the FPPC received regular reports on was regarding staff engagement, discussing both the national staff survey and local 'pulse' survey results. The latter enabled the FPPC to monitor changes and trends in terms of staff engagement, with a view to ensuring actions being taken in response to the results of the national staff survey began to have the desired effect.
- 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.
- Other workforce topics that the FPPC considered over the year included utilisation of eRosters, resourcing activities and the process for the temporary redeployment of staff in response to the pressures of the Covid pandemic.
- The Committee also received regular updates regarding workforce risks and mitigating actions being taken.

Committee member survey

To inform this report a survey was circulated to committee members to gather their views. A summary of the responses received for each question is provided in Appendix 1. On the whole, the responses received were positive, however there are a few suggestions the Committee may want to consider:

- Inclusion of a Transformation and Improvement section.
- To implement a regular meeting between committee chairs, or holding a joint meeting with QSC once a year.
- Presentations involving clinical colleagues to go first on the agenda.

Terms of Reference Review

Following the establishment of a new Strategy Committee and Equality and Inclusion Committee in the last 18 months, the FPPC Terms of Reference have required a more fundamental review than in previous years. The proposed amendments are highlighted in Appendix 2.

Conclusion

The findings of the review indicate that the FPPC has met its duties in the period. The review has not identified any significant issues and in fact has found that the Committee responded effectively to the exceptional challenges faced in the last year, taking an agile and proactive approach to providing assurance to the Board and escalating risks where appropriate.

Some recommendations for minor changes for 2021/22 have emerged from the review:

- To continue to strengthen links with other committees, perhaps through implementing a regular meeting between committee chairs,
- To continue to monitor the forward plan regularly throughout the year to ensure that effective balance is maintained between the operational, financial and workforce domains and duplication with other Committees and the Trust Board is avoided,
- To continue to build into the reports and discussions relating to the finance, performance and people domains an appropriate focus on the system collaboration context.

The Committee's Terms of Reference have been reviewed as part of this process and some updates are proposed. These are primarily to reflect changes of duties and responsibilities in response to the creation of the Strategy Committee and Equality and Inclusion Committee. The updated Terms of Reference are attached as Appendix 1.

The Trust Board is asked to consider the findings of the annual review and approve the amended Terms of Reference.

Appendix 1 – Survey findings summary

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

The respondents agreed the meetings are well structured. One suggestion was to include a specific section on the agenda for Transformation and Improvement.

Do you think the right people are at the meetings for effective discussions and decision making?

All respondents said yes.

How do you feel the Committee has performed against its purpose, as per the Terms of Reference.

- *Maintaining an overview of the development and maintenance of the Trust's medium and long term financial strategy.*
  The respondents agreed this had been achieved

- *Providing scrutiny of operational performance.*
  The respondents agreed this had been done effectively, with some suggestions there could be greater focus on underperforming areas.

- *Monitoring elements of the Trust's people strategy, particularly in relation to resourcing and key controls.*
  The respondents agreed this had improved over the year and was now functioning quite well, a possible exception being headcount controls.

- *Overseeing risk management or the duties of the Committee.*
  It was agreed that there had been good performance in this area.

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

Respondents were in agreement that enough time and attention is given to the key areas of the Committee's remit.

Do you feel the split between finance, performance and workforce has been effective. Could this be improved?

All respondents felt there is equitable balance which has improved in recent months. There was recognition that this caused some challenges with meeting length and on an individual meeting basis there are some occasions where a greater focus on one area over the others may be needed. The benefits of improved triangulation between the domains was noted.

Do you agree that rotating the order of the three main topics should continue or should the order be the same each meeting?

All respondents agreed this has worked well, however operational deep dives being early in the agenda would be preferred to ensure clinical colleagues joining the meeting to present can attend earlier in the day.

Do you think the deep dives are covering appropriate subjects?

All respondents agreed that appropriate subjects are covered.

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

All respondents agreed that they feel able to challenge the Trust.

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 effective links. There were some suggestions for improvement:

- Instigating a regular meeting between Committee Chairs could improve coordination.
- Holding a joint meeting once per year to focus on common issues.

How effectively do you feel the requirements from the last year's review have been addressed?

> *To review and update the schedule for workforce reports to support stronger outcomes and ensure they are strategically focussed.*
>
> The respondents agreed this had, and continued, to improve.
>
> *To continue to monitor the forward planning regularly throughout the year to ensure that duplication with other Committees is avoided.*
>
> The respondents were largely in agreement that this had improved, but would need to continue to be monitored, especially with regard to the new committees that have been established.
>
> *To continue to strengthen the FPPC's approach to risk by ensuring the work of the Committee is focussed by the key risk areas.*
>
> The respondents agreed this had been achieved.

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.

It was agreed this action had been met.

Q12. What do you see as being the main areas for improvement for the FPPC over 2021/2022?

Suggestions included:

- A focus on right sizing the organisation taking into account the planned transfer of MVCC.
- More follow ups on deep dives to gain assurance that actions that were discussed have been taken.
- Effectively integrating and gaining assurance across finance, performance and workforce on integration of services and care pathways across the ICS and ICP.
- Promoting better integrated planning across Trust domains and with system and place partners.
- Ensure discussions are focussed and reflect the top risks and triangulation between committees.
- Build on the consistency of deep dives.

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

Responses included:

- Greater focus and correlation between financial and workforce performance and better balancing of the three core elements of the Committee's work.
- The consistency and quality of papers.
- Good chairmanship and responsive and effective changes in year.
- Responding effectively to the impacts of Covid and enabling the Committee to maintain a clear view of those impacts, their implications and any decisions required.
- Good and effective assurance and overview of financial management-revenue and capital. Good understanding of key risks arising from ongoing changes in the financial framework. Increased understanding of the workforce risks and increasing assurance including understanding of those areas where more granularity is required to gain assurance. Clear and appropriate focus on performance through the pandemic and going forward.

Do you have any other comments?

The only additional comments related to the length of the meeting. It was recognised that this was necessary to accommodate the increasingly rich conversations on the inter relationship between finance, workforce and operational issues, but should be kept under review.

Appendix 2 – Finance, Performance and People Committee Terms of Reference

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE

TERMS OF REFERENCE

1. Purpose

The purpose of the Finance, Performance and People Committee is to provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and workforce 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;
- overseeing risk management for the duties of the Committee.

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

2. Status & Authority

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

3. Membership

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

Core Attendees:

- Chief Executive
- Director of Finance
- Chief Operating Officer
- ~~Director of Strategy~~
- Chief People Officer
- Director of Nursing
- Medical Director

Attendees:

- Trust Secretary
- Director of Strategy
- Associate Director of Governance
- Chief Information Officer
- Director of Improvement and Transformation
- Deputy Director of Finance Financial Management
- Deputy Director of Finance Financial Planning
- Deputy Director of Workforce and OD

Formatted: Font: Bold

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

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

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

4. Quorum

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

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

5. Frequency of meetings

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

6. Duties

6.1 Financial Planning

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

To approve:

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

To approve and recommend to the Board:

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

To monitor and review:

- Financial impacts relating to ~~Enabling~~ 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-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~~Financial implications relating to the system collaboration framework;
- The development of financial forecasts and measures taken to promote financial sustainability.

6.2 Investments

To recommend to the Board:

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

To monitor and review:

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

6.3 Financial Performance

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

To determine or approve:

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

To recommend to the Board:

- The application of contingency funding where appropriate;

To monitor and review:

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

6.4 Operational Performance

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

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

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

To work closely with the QSC to understand any quality and safety implications associated with operational performance.

To be kept appraised of operational performance matters relating to system collaboration.

To receive an agreed programme of deep dives relating to significant operational issues.

6.5 Workforce

To monitor and review:

- The implementation of the People Strategy, in particular relating to the 'Work Together', 'Thrive Together' and 'Care Together' pillars, and key indicators in relation to finance and performance;
- Reports relating to the above, including:
  - workforce planning and deployment, ~~inclusion,~~
  - resourcing,
  - temporary staffing,
  - employee relations,
  - Health and wellbeing,
  - ~~s appraisals and statutory and mandatory training, and~~
  - ~~staff survey actions~~Engagement and staff experience (including staff survey results).
- Any other workforce matters deemed relevant to the role of the Finance, Performance and People Committee (as opposed to the QSC or Equality and Inclusion Committee).

Formatted

Formatted: Indent: Left: 2.54 cm, No bullets or numbering

6.6 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.

6.7 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~~ Committee and Executive Directors for these groups/individuals to take appropriate action.

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

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

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

9. Support

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

East and North Hertfordshire NHS Trust

Agenda Item: 13.2 a)

TRUST BOARD - PUBLIC SESSION – 3 NOVEMBER 2021
QUALITY & SAFETY COMMITTEE – MEETING HELD ON 28 SEPTEMBER 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of 28 September 2021 to the Board.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Trust Secretary

Trust priorities to which the issue relates:		**Tick applicab**
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):

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

QUALITY AND SAFETY COMMITTEE MEETING – 28 SEPTEMBER 2021

SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 3 NOVEMBER 2021

The following Non-Executive Directors were present:

Ellen Schroder, Peter Carter, David Buckle, Val Moore

The following core attendees were present:

Nick Carver, Michael Chilvers, Rachael Corser, Thomas Pounds, Jude Archer

Matters Considered by the Committee:

Risk Report and Board Assurance Framework

The Committee received the Risk Report and the latest edition of the Board Assurance Framework and was informed that a number of new risks had been added to the latter with some still awaiting divisional test and challenge.

Discussion was held around the resourcing challenges in maternity and the Committee was informed that there was a lot of proactive work being undertaken and the international recruitment was developing at pace.

Deep Dive: Quality and Safety Digital Update

The Chief Nurse introduced the paper on the quality and digital partnership. She noted that the National Digital Patient Safety Strategy had just been published and there was a national focus on this area.

The following points were drawn to the Committee's attention:

- The Digital agenda aligned with a number of the actions in the Journey to Excellence.
- The approach to safety was balanced between Safety I (reactive approach) and Safety II (proactive approach). There would be a focus on strong management infrastructure of safety critical information.
- The Keeping Our Patients Safe (KOPS) digital programme was giving staff the tools for safe handovers.

The next steps in the strategy were highlighted. The Committee discussed the challenges in relation to the size of the agenda and monitoring progress. The Committee noted the report and expressed their thanks to the presenters.

Quality and Safety Report (Month 5)

The Committee received the latest edition of the Quality and Safety Report and was informed that the IPC report was now included within this report and the Safer Staffing report would be integrated from the next meeting.

Key points discussed included:

- The Committee noted that the number of serious incidents had increased but the improvement trajectory is on track.
- The rate of C.difficile infections had increased within the Trust and on a national level.

- VTE, sepsis and HAT were areas where improvements in performance were being sought. There had been areas of improvement with VTE and the opportunity to learn from the teams with improved performance.
- The Committee heard that there had been improvement in the timeliness of response to complaints and the Trust was focusing on reducing the number of complaints outstanding.

Maternity Reports

The Committee received the Maternity Safety Highlight Report which provided the data measures for overview as per the perinatal quality surveillance model. The Committee discussed some of the challenges in relation to midwifery staffing and the impact on training compliance rates.

Two teams were in place on the Continuity of Carer plan and a decision had been taken to pause any further rollout during this period of challenge around staffing. A plan was in place to roll out a third team at a later date.

The Committee received the Perinatal Mortality Review and noted that during the quarter from April to June 2021 the Trust remained 100% compliant with safety action 1 of the Maternity Incentive Scheme and the Ockenden actions.

The Committee noted the latest maternity reports.

Safer Staffing Report

The Committee received the latest Safer Staffing Report. It was noted that there was a high caliber of international nurses being recruited into the Trust. There had been good ICS collaboration around maternity and they were working collectively to look at the training programme for international midwives.

Clinical Harm Reviews Update

The Committee discussed the latest position in relation to the clinical harms review process. There had been good progress in cancer clinical harm and the quality of the process had improved. The clinical harm reviews for long waiters were being taken at the time the surgeon treated the patient. The Committee was informed that a meeting was being held across the ICS to consider standardising the approach to harm reviews, especially for PTLs.

Deteriorating Patient Update

The Committee received the Deteriorating Patient Update which outlined the aims and challenges in improving recognition, response and management of the deteriorating patient and the next steps that would be taken.

Learning from Deaths Report

The Committee received the Learning from Deaths report. The Committee heard that mortality as measured by HSMR and SHMI was better than expected but had plateaued with no change for the last few months. Crude mortality is 1.41% for the 12 month period to July 2021 compared to 1.25% for the latest 3 years.

Reducing Avoidable Variation Report and 7 Day Working

The Committee received and noted the Unwarranted Variation, Getting it Right First Time

(GIRFT) and 7 Day Services Report. The Trust was working towards achieving the Keogh standards and some changes to services had been made during the Covid pandemic which supported the achievement of certain standards.

Estates and Facilities and H&S Report

The Committee received the Estates & Facilities Health & Safety Assurance Report which identified the level of assurance that currently exists within the estates and facilities team with regard to statutory compliance items.

Compliance Report

The Committee received the Compliance Report in a revised format and heard that the CQC were continuing with TMAs currently although they had not yet finally confirmed their new inspection regime. Monthly Quality Assurance visits had re-commenced. In response to challenges being faced in Maternity services across the region, joint fortnightly meetings were being held with the CCG, CQC, NHSE/I, LMNS and NMC to provide additional assurance.

Responsible Officer / Revalidation Annual Report

The Committee received the report and was informed that the appraisal process which had been suspended from March 2020 due to COVID had now been reinstated with the goal for the coming year being 95% compliance. Processes and training had been improved. Fitness to practice was up for review nationally. The QSC supported the submission of the annual report to the Trust Board.

The Committee noted the following reports:

- Integrated Performance Report
- Maternity and Neonatal Dashboards (from July and August)
- QSC Sub-Committee Escalation Report
- Quality & Safety Report - Month 4 (from July)
- Safer Staffing Report (from July)

Peter Carter
Quality and Safety Committee Chair
November 2021

East and North Hertfordshire NHS Trust

Agenda Item: 13.2 b)

TRUST BOARD - PUBLIC SESSION – 3 NOVEMBER 2021
QUALITY & SAFETY COMMITTEE – MEETING HELD ON 26 OCTOBER 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of 26 October 2021 to the Board.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Trust Secretary

Trust priorities to which the issue relates:		**Tick applicab**
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):

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

QUALITY AND SAFETY COMMITTEE MEETING – 26 OCTOBER 2021
SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 3 NOVEMBER 2021

The following Non-Executive Directors were present:

Ellen Schroder, Peter Carter, David Buckle, Val Moore

The following core attendees were present:

Nick Carver, Michael Chilvers, Julie Smith, Jude Archer, Mel Gunstone (deputising for Rachael Corser)

Matters Considered by the Committee:

Board Assurance Framework

The Committee received the latest edition of the Board Assurance Framework. The Committee heard that winter pressure and staffing were continuing to impact activity not only within the Trust but also with system partners and this would be kept under review.

A routine deep dive on BAF Risk 8 – Quality had been presented to the Audit Committee where discussion was held around the impact of the backlog of activities and changes to pathways. Assurance was given on the role of oversight from the Quality & Safety Committee.

New and Emerging Risks

The Committee were informed that five new risks had been added to the corporate risk register since the September QSC meeting. Two had received final approval by the Divisions and three still required final approval. Mitigating actions were in place for each of the risks.

Quality and Safety Report (Month 6)

The Committee received the latest edition of the Quality and Safety Report and was informed that the Safer Staffing report was now included within this report.

Key points discussed included:

- The overall number of patient safety incidents and serious incidents being reported was now back to pre-pandemic levels.
- Work was progressing on sepsis compliance within the ED and the wards. A VTE lead had been appointed to assist with improvement in the VTE area.
- There was a challenge with the increase in asymptomatic COVID patients.

Maternity Reports

The Committee received the Maternity Safety Highlight Report which provided the data measures for overview as per the perinatal quality surveillance model. The Committee heard some of the challenges in relation to midwifery staffing and the impact on training compliance rates. Discussion was held around actions taken to improve the uptake of COVID vaccinations in pregnant women.

The Committee was informed that the Ockenden compliance report had been received and looked positive. A highlight report would be brought to the November Quality & Safety Committee meeting.

In regard to the Continuity of Carer, new guidance had been released which recognised the challenges around staffing and the drive to maintain a safe service. The guidance would be considered and further updates would be brought to a future QSC meeting.

The Committee noted the latest maternity reports.

Clinical Harm Reviews Update

The Committee discussed the latest position in relation to the clinical harms review process. The Committee was informed that a meeting had been held across the ICS to consider standardising the approach to harm reviews, especially for PTLs. There was a need to identify and prioritise those who may not have had a face to face consultation with their GP in order to undertake a clinical harm review and follow the waiting well process.

Incidents and Inquests Report

The Committee noted the Incidents and Inquests Report which reviewed reported safety incidents by division, level of harm and category. It was noted that incident reporting had returned to pre-pandemic levels and the review and closure of open incidents remained a priority for the Divisions.

Neck of Femur Mortality Action Plan

The Committee received an update on the review and actions taken since the outlier alert from the National Hip Fracture Database was received in May 2021. The Committee were informed that progress against the action plans would be monitored via the Mortality Surveillance Committee with updates provided to the Trust Executive meeting on a monthly basis. A final report would be provided to the Quality and Safety Committee when outputs of a review by the CCG had been received.

Mental Health Update

The Committee was provided with an update on the work in progress related to the Trust's mental health agenda, the collaborative work with system partners, and development of the mental health strategy. Challenges remained around the increased number of patients requiring mental health input at any one time along with the reduction in local and national mental health bed availability, especially the specialist tier four beds. Therefore patients are being required to be admitted to the acute hospital, some with prolonged stays. The Committee recognised the work the teams and Executives are doing with partners to access the appropriate placements as soon as possible and mitigate the risks as much as possible whilst they are in our care. The Committee heard that to ensure patients with mental health needs received the best care and support, various work streams were underway across the Trust as well as working closely with partners including Hertfordshire Partnership Foundation Trust (HPFT) and Hertfordshire Police.

Emergency Preparedness

The Committee received and noted the progress against the Emergency Preparedness Resilience and Response programme and the readiness of the Trust for business continuity events and major incidents. The Committee were informed that there were no issues to be escalated. It was noted that the Trust remains fully compliant against the NHS England EPRR Core Standards Assurance rating.

Junior Doctors Contract Quarterly Update

The Committee received and noted the Junior Doctors Contract Quarterly Report. The report was largely based on exception reporting and three patient safety reports. The Committee was informed that there were no breaches of safe working hours during the period and no significant

issues were raised from the exception reporting. The Committee also heard that a junior doctor had volunteered to be the Trust Champion for Exception Reporting in order to encourage a higher level of reporting in this area.

QSC Annual Review and Review of Terms of Reference

The Quality & Safety Committee Annual Review for 2020/21 was presented to the Committee. The annual review concluded that the QSC had met its duties under its Terms of Reference but recognized there were areas where changes were being made to improve the effectiveness of the Committee. Some minor changes were suggested to the Terms of Reference.

The Committee noted the following reports:

- Integrated Performance Report
- Maternity Dashboard

Peter Carter
Quality and Safety Committee Chair
November 2021

East and North Hertfordshire NHS Trust

Agenda Item: 13.2.1

TRUST BOARD PUBLIC MEETING – 3 NOVEMBER 2021
QUALITY AND SAFETY COMMITTEE ANNUAL REVIEW 2020-21

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 2020/21. The review concludes that the QSC has fulfilled its duties under its terms of reference, but recognises there are areas where changes are being made to improve the effectiveness of the Committee.

The Committee's terms of reference have been reviewed and the proposed amendments are highlighted in Appendix 1. There are no significant changes proposed on this occasion.

To support strengthening the effectiveness of the Committee, it is recommended that the changes already discussed and agreed with the QSC chair are enacted (as detailed in the report).

It is also worth noting that a recommendation arising from the latest FPPC and Audit Committee reviews was to continue to strengthen links with other committees, perhaps through implementing a regular meeting between committee chairs.

The Trust Board is asked to consider the findings of the annual review and approve the amended Terms of Reference.

Action required: For approval

Previously considered by:
QSC – 26.10.21

Director:	**Presented by:**	**Author:**
Director of Finance	Chair of QSC	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 2020/21

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 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 relating to workforce capability and development, such as education and talent management, or where there is a clear and direct link to quality and safety issues. The Committee will be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the Trust's Clinical Strategy 2019-2024 and Quality Strategy.'

This annual review considers how the QSC has met its duties under its terms of reference over the course of 2020/21. 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 concludes that the QSC has fulfilled its duties under its terms of reference, but recognises there are areas where changes are being made to improve the effectiveness of the Committee.

To support strengthening the effectiveness of the Committee, it is proposed that the Committee ensures the actions already agreed with the QSC Chair regarding improving the effectiveness of the meetings are implemented (as detailed later in the report).

The Committee's terms of reference have been reviewed and the proposed amendments are highlighted in Appendix 1. There are no significant changes proposed on this occasion.

The Trust Board is asked to consider the findings of the annual review and approve the amended Terms of Reference.

Summary of Key Findings

Meetings and Membership

The QSC met each month in 20/21 with the exception of August (when no Board committees are routinely scheduled). At the outset of the year at the start of the Covid pandemic there were two meetings that were held jointly with the FPPC.

There were no personnel changes affecting the QSC over 2020/21. 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 2020/21 are reflected in the Trust's annual report. It is worth noting that there was a

brief period during the pandemic when due to Covid restrictions Dr Carter asked Mrs Schroder to chair the meetings as she was on site whilst he was attending remotely.

QSC meeting format

Prior to the Covid pandemic the QSC trialled a period of holding 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 to streamline the agendas due to the Covid pandemic. A return to a mix of deep dives and regular reports was resumed as Covid pressures eased and following feedback and discussion with Committee members it has been agreed to return to this format going forward.

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.

Do the agenda and annual cycle cover the correct topics? If not, which other topics do you think should be included?
The respondents agreed that the agendas broadly cover the correct topics, though it was suggested there could be more emphasis on the areas of higher risk.

Do you feel that there is adequate time to discuss each topic in detail?
The responses to this question indicated that this is not always achieved. Respondents commented on the size of the agenda and the need to prioritise. It was recognised this was currently being considered. It was also suggested that clearer and more focussed papers would enable more efficient discussions.

How could the quality of discussions be improved?
Most respondents agreed that improvements to the papers in terms of summaries and clarity of purpose would help to improve quality of discussions.

Are discussions summarised and is the conclusion clear?
Respondents said this was mostly achieved. In terms of conclusions in papers, it was suggested these could sometimes be strengthened.

Are the appropriate people at the meeting?
Most respondents commented on the benefits of being joined by report authors as the subject matter experts for the discussion of certain papers, as has been happening for the last couple of QSC meetings.

Do you feel that enough time and attention is given to the key areas of the Committee's remit (see Terms of Reference for further details)?

1. *Managing quality and safety risks*
2. *Ensuring compliance*
3. *Improving quality*

Respondents mostly felt that these areas had enough time and attention. Of the three areas, the area most respondents felt would benefit most from more time and attention was 'Improving quality'. It was also noted that there was some overlap with FPPC deep dives and ensuring the Committee were aware of these deep dive sessions would strengthen coverage of some of these points.

Do you feel able to challenge the Trust at the meetings?
Respondents mostly agreed they felt able to challenge the Trust at the meetings.

How has the Committee added value to the Trust's operations over the last year?
Responses included: by providing oversight, developing understanding of risks and mitigations, and raising the profile of quality and safety.

Any other comments as to how the Committee's effectiveness could be improved?
Comments included:
The Committee generally functions well. Good chairing and challenge from NEDs
More opportunities for patient stories and pathways,
The role of the QSC sub-committees was noted and it was suggested that the Committee might benefit from assurance at an appropriate time regarding their relative effectiveness,
More focussed papers would be beneficial.

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 cover the key strategic risks. These items remained as core items even in the period in which agendas were streamlined due to Covid pressures.

The QSC has been kept informed of the developments regarding CQC engagement and informed of progress against key actions arising from reviews.

The Committee has also been kept informed of estates and facilities compliance and risks. The Committee has witnessed the development of estates and facilities dashboards which provides a much improved oversight of estates and facilities compliance and risks.

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 as well as regarding the arrangements in place to manage the Trust's response to the Covid pandemic.

The QSC has resumed its programme of deep dives covering topics including sepsis, discharges and harm reviews. Any significant issues were highlighted to the Trust Board through the QSC summary reports.

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 and assurance on measures being taken to mitigate any staffing challenges. Going forward this information will be incorporated in the 'Quality and Safety Report'.

The QSC has continued to receive regular updates 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. IPC has also been a particular focus in relation to the Covid pandemic.

The QSC has continued its role of reviewing and endorsing the annual responsible officer's report regarding medical staff revalidation prior to submission (the national process was altered in 2020 due to the Covid pandemic, however the Committee has reviewed the report in 2021).

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 and emergency planning.

The QSC has also reviewed and approved a number of annual reports including the Health and Safety Annual Report and Safeguarding Annual Report (these two particular reports are referred to the Trust Board for final approval).

The QSC received the draft Quality Account for comments and approval at the meeting on 29 June 2021 (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 Key Performance Indicators and work commencing for the formal revalidation of the partnership, scheduled for 2023.

The QSC has continued to closely monitor the Trust's mortality rates, which continued to compare favourably 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.

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 QSC has continued to monitor new, ongoing and closed incidents and serious incidents, including trends and key themes, prior to further discussion at Trust Board meetings.

The QSC has also continued to closely monitor complaints data, including response times and the common categories for complaints as well as being kept informed of challenges being experienced in terms of an increase in complaint numbers. The Committee have also reviewed the feedback from external surveys regarding patient experience.

The Committee has continued to receive updates on the quality improvement work taking place across the Trust.

From a workforce perspective, the Committee has received reports on issues including statutory and mandatory training and the quarterly reports from the Guardian of Safe Working Hours.

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 the impact of the Covid pandemic to a greater extent than most 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 now returned to a more regular format.

Changes that are already underway

As some of the more immediate pressures resulting from the pandemic eased and the Committee was able to move away from the streamlined meetings, it became apparent that the agendas needed to be reviewed to ensure the meetings remained effective and efficient. The size of the agenda and meeting papers was highlighted by the committee members as impacting on the ability to prioritise and focus the Committee's attention as effectively as possible. Consequently, the QSC Chair, a NED committee member (Dr Buckle) and the Chief Nurse and Medical Director have met with the secretariat team to discuss and agree changes to improve the effectiveness of the meetings. It was agreed that a pre-meet consisting of all those listed above will take place before each meeting to assist with prioritising agenda items, there will be a focus on ensuring cover sheets and papers are succinct and clearly specify the purpose and key points for the Committee to consider and report authors and subject matter experts will join the meetings when their reports are being considered. Initial steps have been taken towards each of these changes and it is recognised that some changes may take more time to implement than others.

The role of the sub-committees was also discussed and the possibility of revisiting those arrangements to ensure adequate assurance is provided was noted.

It is also worth noting that a recommendation arising from the latest FPPC and Audit Committee reviews was to continue to strengthen links with other committees, perhaps through implementing a regular meeting between committee chairs.

Conclusion

The review concludes that the QSC has fulfilled its duties under its terms of reference, but recognises there are areas where changes are being made to improve the effectiveness of the Committee.

The Committee's terms of reference have been reviewed and the proposed amendments are highlighted in Appendix 1. There are no significant changes proposed on this occasion.

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

- To ensure the actions already agreed with the Chair regarding improving the effectiveness of the meetings are implemented:
    - -To ensure cover sheets / executive summaries are clear and provide the basic detail and highlight key issues for consideration by the Committee,
    - -To ensure reports are not overly lengthy (additional information could be provided as an appendix when required)
    - -To trial increased attendance from report authors / subject matter experts for discussion of their reports,
    - -To continue to ensure a pre-meet takes place before each meeting to assist with appropriate prioritisation of topics for the meetings. This can be used to inform any changes to the annual cycle reporting arrangements.

It is also worth noting that a recommendation arising from the latest FPPC and Audit Committee reviews was to continue to strengthen links with other committees, perhaps through implementing a regular meeting between committee chairs.

The Trust Board is asked to consider the findings of the annual review and approve the amended Terms of Reference.

East and North Hertfordshire NHS Trust

QUALITY AND SAFETY COMMITTEE
TERMS OF REFERENCE

1. Purpose

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

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

2. Status and Authority

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

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

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

3. Membership

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

Core Attendees

Chief Executive
Chief Nurse
Medical Director
Chief Operating Officer
Chief People Officer
~~Director of Strategy~~
Associate Director of Governance

Other attendees:
Chief Pharmacist
Patient Safety Leads
Trust Secretary
Director of Midwifery
Director of Estates and Facilities
Director of Improvement

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

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

4. Quorum

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

5. Frequency of Meetings

The Committee will normally meet monthly with the exception of August (unless a meeting is required). The format of the meetings will be agreed with the Committee Chair and some meetings may include a focus on deep dive presentations if deemed appropriate and effective. The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

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

6. Duties

Managing Quality and Safety Risks

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

- ~~To receive 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.
- 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~~the 'Grow Together' pillar of the People Strategy, including regarding learning and education, statutory and mandatory training, talent management, ~~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 the above listed workforce areas, liaising with the Finance, Performance and 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 Trust Secretary will ensure the committee is supported administratively and advising the Committee on pertinent areas.

East and North Hertfordshire NHS Trust

Agenda Item: 13.3

TRUST BOARD - PUBLIC SESSION – 3 NOVEMBER 2021

AUDIT COMMITTEE – MEETING HELD ON 19 OCTOBER 2021

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the Audit Committee meeting of 19 October 2021 to the Board.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of AC	**Presented by:** Chair of AC	**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) N/A
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

AUDIT COMMITTEE MEETING – 19 OCTOBER 2021
SUMMARY TO THE TRUST BOARD MEETING HELD ON 3 NOVEMBER 2021

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

Internal Audit Reports:

Internal Audit Progress Report and Action Log
The Audit Committee received an update from the Internal Auditors. Four internal audit reports had been finalised since the previous meeting, as follows:

- Cyber Security Maturity Assessment – (Advisory)
- Transformation Plans – Reasonable Assurance
- Capital Programme – Reasonable Assurance
- Budget Setting and Financial Reporting – Reasonable Assurance

The Committee discussed the actions to achieve the cyber security maturity level. It was noted that cyber security was being assessed again in Q4 when consideration would be given to the controls in place.

In terms of progress against the annual plan, six reports have been finalised with some slippage with Q2 audits however these should be completed by the end of October. The Committee heard that all Terms of Reference for Q3 audits had been issued and are being booked.

The Committee also received the latest internal audit actions tracker. It was noted that the total number of overdue actions had reduced from the previous meeting.

Counter Fraud Progress Report
The Committee received the Counter Fraud Progress Report which detailed the activity carried out against the Counter Fraud work plan 2021/22 since the Audit Committee of 19 July 2021. The Committee was informed of the work being undertaken to improve the Trust's Government Functional Standards rating during 2021/22. Work undertaken included completion of the NHS CFA COVID-19 Post Event Assurance Exercise.

External Audit Reports:

ENH Charitable Fund Final Audit Completion Report
The Committee received and noted the latest version of the ENH Charitable Fund final audit completion report for the year ended 31 March 2021. The final report would be brought to the Trust Board at the meeting of 3 November 2021 for consideration and noting.

Charity Annual Report and Accounts
The Committee received and noted the final draft of the Charity Annual Report and Accounts. Final approval would be sought by the Trust Board at the meeting of 3 November 2021.

Other Reports:

Board Assurance Framework 2021/22
The Committee was presented with the current BAF and informed that it had been through the scrutiny of each of the Board Committees and the Board. No further changes to risk scores had occurred over the previous two months.

Deep Dive – Quality
A routine deep dive on BAF Risk 8 - Quality was presented to the Committee as part of the assurance cycle. The Committee was reassured that the Quality & Safety Committee was taking the role of oversight very seriously and a robust plan was in place to hold deep dives into areas of pressure. Discussion was held around the impact of the backlog of activity, the current activity pressures and changes to pathways in the context of quality and safety. Assurance was given on the actions being taken.

Audit Committee Annual Report and Terms of Reference
The Audit Committee Annual Evaluation and Review of Terms of Reference was presented to the Committee. The annual review concluded that the Audit Committee had met its duties under its Terms of Reference. Some minor changes were suggested to the Terms of Reference.

Review of SOs and SFIs
The Committee received a report containing proposed amendments following the annual review of the East and North Hertfordshire NHS Trust Standing Orders and Standing Financial Instructions. The Committee recommended the revised SOs and SFIs for approval by the Board.

Managing Conflicts of Interest
The Committee received an update regarding the Trust's processes for managing conflicts of interest and heard that the Trust had procured an electronic system for administering the registers. Preparations for the implementation of the new system were underway.

Cyber Security Report
The Committee received the latest update regarding the Trust's cyber security position. The Committee noted the progress with desktop and laptop patching and the timeline for server remediation.

Data Quality and Clinical Coding Report
The Committee received and noted the update of data quality and clinical coding activities. The Committee noted the data quality training packages being developed and the different projects the Data Quality team were working on including the creation of a KPI dashboard to help the divisions focus on areas of concern in regard to data quality.

Jonathan Silver
Audit Committee Chair
November 2021

East and North Hertfordshire NHS Trust

Agenda Item: 12.3.1

TRUST BOARD - PUBLIC SESSION – 3 NOVEMBER 2021

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. 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 2020/21, 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 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:

- To continue to maintain the focus on implementation of the findings of internal audits,
- To continue to strengthen links with other committees, perhaps through implementing a regular meeting between committee chairs.

The terms of reference have been reviewed and some minor changes are suggested. The proposed amendments are highlighted in Appendix 1.

The Trust Board is asked to consider the findings of the annual review and approve the amended Terms of Reference.

Action required: For approval

Previously considered by:
Audit Committee – 19 October 2021

Director:	**Presented by:**	**Author:**
Director of Finance	**Trust Secretary**	**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):

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

AUDIT COMMITTEE
ANNUAL REVIEW 2020/21

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 2020/21, 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 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:

- To continue to maintain the focus on implementation of the findings of internal audits,
- To continue to strengthen links with other committees, perhaps through implementing a regular meeting between committee chairs.

The terms of reference have been reviewed and some minor changes are suggested. The proposed amendments are highlighted in Appendix 1.

The Trust Board is asked to consider the findings of the annual review and approve the amended Terms of Reference.

Summary of Key Findings

- **Meetings and Membership**

The Audit Committee met formally on five occasions during 2020/21. There were no significant changes to the meeting format and membership over 2020/21, with the meetings and agendas running mostly to the original schedule despite the pressures of the Covid pandemic. The membership of the Committee remained the same during the course of the year, with Mr Jonathan Silver continuing as Chair and Mr Niven and Mrs McConnell remaining as members of the Committee throughout the period.

2020/21 marked the first year that the Internal Audit and Local Counter Fraud Specialist / Anti-Crime Specialist function was provided by TIAA, whilst External Audit services continued to be provided by BDO.

Whilst the Committee did not formally meet in private with the auditors on a regular basis during 2020/21, the Audit Committee Chair and the Director of Finance were separately and jointly in contact with the auditors throughout the period and in advance of the 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.

A review of the Committee's minutes demonstrated an appropriate level of scrutiny and challenge could be evidenced throughout its meetings.

- **Committee Survey**

The views of the Audit Committee members and regular attendees have also been sought via a survey. There were a total of six responses. A summary of the findings regarding each survey question are provided below:

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

The respondents were largely in agreement that agendas and papers are structured effectively. There was a suggestion a small number of papers could be more focussed.

What other areas (if any) should the Committee cover?

Respondents mostly agreed that the Committee covered the right areas already. There was a suggestion that governance frameworks relating to the Trust's work within HCP's could be considered in the future.

Are the appropriate people at the meeting?

The respondents agreed that the appropriate people are at the meetings. There was support for continuing to invite managers for discussion of relevant agenda items / where actions have not progressed as planned.

Is there sufficient time to discuss key agenda items and is the Committee focused on the right issues?

The respondents felt that there is sufficient time available to discuss key agenda items.

How could the quality of discussions be improved?

Suggestions included:

- Including more examples of best practice from other organisations from the auditors.
- A further push to address the small number of unresolved long-standing issues.

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

All respondents felt able to challenge the Trust at the meetings.

How has the Committee added value to the Trust's operations over the last year?

In summary, respondents said this had been achieved through good check and challenge around the major risks the Trust is facing and good coverage of the core areas of the Committee's remit.

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

The respondents felt the approach had been effective – there was support for continuing the programme of risk deep dives. There was also a comment on the need to ensure new and emerging risks should also be considered – such as those arising from system working and other areas of change, e.g. digital.

With regard to other Board Committees, do you think there are effective links with the other Committees?

Respondents mostly agreed this was effective. It was commented that this could be enhanced by periodic meetings with the Chairs of other committees.

How effective do you think contributions and input have been from the internal and external auditors over the last year (April 2020 - March 2021)?

Respondents were positive about the good contributions from TIAA in challenging circumstances. The challenges associated with the delivery of the external audit work plan for 20/21 was noted.

Any other comments as to how the Committee's effectiveness could be improved?

The respondents felt that overall the Committee was functioning well.

How do you feel the Committee has performed against the recommendations made in last year's review? Please provide examples:

1: Some tightening and strengthening of administrative processes - including regarding report length and clarity of purpose.

2: To maintain the focus on implementation of the findings of internal audits.

Answers in summary were:

1. This has improved. A small number of papers could potentially be improved further

2. This has also improved but there is further work to do to ensure actions are implemented in a timely way. There was recognition that the impact of the Covid pandemic did not help in this regard.

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 continued to receive and review the latest iteration of the BAF at each meeting, except for the meeting dedicated to reviewing the annual report and accounts. The Committee considered the proposals for the annual review of the BAF at the meeting in July 2020 (slightly later in the year than usual due to the pressures of the Covid pandemic). BAF risks continued to be assigned to the appropriate Board sub-committee (QSC, FPPC, Strategy Committee or latterly Equality and Inclusion Committee) whilst the Audit Committee was concerned with monitoring the process and systems of risk management as a whole. However, the Audit Committee also continued a programme of deep dives into specific risks at each meeting.

In June 2020 the AC reviewed and endorsed the final draft of the Annual Governance Statement (AGS) 2019/20. This concluded the period in which the service was provided by RSM UK. 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 2020/21 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 2020.

With support from the new LFCS/ACS service provider, the Committee also reviewed and approved the updated Anti-Fraud and Bribery Policy.

- **Internal Audit**

The Committee received regular progress reports from its new internal auditors (TIAA) on internal audit work undertaken during 2020/21. The audits received by the Committee over the year covered areas including clinical audit, payroll, health and safety, Covid-19 Financial Governance, E-rostering and To Take Out Medicines and Discharge Summary Processes.

The Committee discussed in more detail the audits that received only a 'limited assurance' opinion, often inviting the lead director to the meeting to discuss the findings. There were no 'no assurance' opinions issued during the year and six 'Substantial Assurance' opinions.

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. The Audit Committee has recognised there has been progress in this area despite the challenges caused by Covid, but has also recognised that there is further room for improvement. The Committee invited relevant managers to attend meetings to discuss the actions that had been overdue for a significant period of time.

At the March 2021 meeting, the Committee received the Head of Internal Audit's draft opinion, which would be included within the AGS for 2020/21:
'TIAA is satisfied that, for the areas reviewed during the year, East and North Hertfordshire NHS Trust has reasonable and effective risk management, control and governance processes in place. ….'
The final opinion issued was unchanged from the draft received at the March meeting.

The proposed Internal Audit plan for 2021/22 was presented to the Audit Committee in March 2021 and was drafted with consideration of the most significant risks affecting the Trust.

- **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 2020/21 and received the planning report from the External Auditors in January 2021 and updates on progress at the subsequent meetings.

For the 2020/21 audit, a 'Value for Money Report' replaced the requirement for the auditors to provide a letter of representation. This was circulated for review and approval by email on this occasion. In future, the expectation is that the report will be produced at the same time as the audit completion report.

The Committee was kept informed of provisions that had been made for delaying submission of the annual report and accounts as a result of Covid pressures and the Trust Board granted delegated authority to the Audit Committee for final approval of the Annual Report and Accounts. These were approved in correspondence and submitted on 5 July 2021.

The Committee also received updates regarding the Trust Charity and the ENH Pharma Ltd accounts. The audits for the Charity accounts 2020/21 are due to be completed in October 2021. The ENH Pharma accounts are consolidated into the Trusts accounts. The external audit of the ENH Pharma accounts has also been completed.

- **Other Assurance Functions**

Other assurance functions undertaken by the Audit Committee in 2020/21:
- The Committee received updates regarding Accounting policies.
- The Committee has received regular updates from the Data Quality and Clinical Coding teams.
- The Committee received updates regarding Clinical Audit, which were also considered by the QSC.
- 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 and tenders and waivers.

- The Committee approved the updated policy for Managing Conflicts of Interest and the new Credit Card policy.
- 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/Anti-Crime Specialist throughout the year, a service provided by the Trust's new internal auditors TIAA.

The Committee 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 the Trust's Government Functional Standard submission and the findings of thematic reviews conducted, including a Covid-19 fraud risk thematic review. Completion of actions arising from LCFS thematic reviews was also monitored.

The AC approved the LCFS work plan for 2021/22 at the meeting on 24 March 2021.

The Annual report for 2020/21 was considered at the 4 June 2021 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. Due to the timeframes involved this year, the Trust Board granted delegated authority to the Audit Committee to approve the Annual Report and Accounts. The Chair of the Audit Committee reported back to the Trust Board once this had been completed and highlighted any significant issues.

Conclusion

This review concludes that the Committee met its duties under its terms of reference. 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:

- To continue to maintain the focus on implementation of the findings of internal audits,
- To continue to strengthen links with other committees, perhaps through implementing a regular meeting between committee chairs.

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 Annual Governance Statement), 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 Authority ~~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~~ Auditor's Annual Report (including Value for Money Report) 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,~~ [*Now considered by the Strategy Committee*]

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 (SC), Equality and Inclusion Committee (EIC) 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.

East and North Hertfordshire NHS Trust

Agenda Item: 13.3.2

TRUST BOARD - PUBLIC SESSION – 3 NOVEMBER 2021

STANDING ORDERS, RESERVATION AND DELEGATION OF POWERS AND STANDING FINANCIAL INSTRUCTIONS ANNUAL REVIEW

Purpose of report and executive summary (250 words max):
Please find attached the proposed changes resulting from the annual review of the East and North Hertfordshire NHS Trust Standing Orders and Standing Financial Instructions.

The review has identified some minor amendments required, in particular regarding:

- information on the Board Committees (the addition of the Equality and Inclusion Committee and updated references to the Remuneration Committee following revisions made to its Terms of Reference earlier this year),
- Updated references to EU regulations,
- Some minor changes to terminology following a review by the Anti-Crime Specialist and to the 'Invitation to tender' section to address an action from an ACS thematic review,
- References to the procurement service (now Hertfordshire and West Essex ICS Procurement Services), electronic tender system and OJEU limits,
- Some updates to the declarations of interest section, in line with the NHSE Standing Orders.

The changes are highlighted via tracked changes for ease of reference. *(Note: contents page/page numbers will be updated in the final version).*

The Audit Committee is also asked to note that the recently appointed Director of Procurement is commencing work on the alignment of each partner organisation's SFIs and it is proposed that any changes resulting from this review are presented to a future Audit Committee meeting for consideration.

The Trust Board is requested to review and approve the proposed revisions to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

Action required: For approval

Previously considered by:
Audit Committee – 19.10.21

Director:	**Presented by:**	**Author:**
Director of Finance	**Director of Finance / Chair of Audit Committee**	**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

East and North Hertfordshire NHS Trust

TRUST-WIDE POLICY

for

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

A document recommended for use

In: Trust-wide

By: All staff

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

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

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

Approved by:
Audit committee

Trust Ratification: Trust Board

Mrs Ellen Schroder (Trust Chair),

Policy issued:

To be reviewed before:

To be reviewed by: Trust Secretary / Financial Controller

Doc Registration No. CG05 **Version No.**

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

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

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

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

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

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

Key messages

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

EAST AND NORTH HERTFORDSHIRE NHS TRUST

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

October 2020~~0~~1

Page

CONTENTS

SECTION A

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.2.23 **Officer member** means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member).

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

1.2.25 **SFIs** means Standing Financial Instructions.

1.2.26 **SOs** means Standing Orders.

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

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

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

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

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

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

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

(5) The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies. Furthermore the Trust has delegated powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation..

(6) The Code of Accountability for NHS Boards (DH, revised April 2013) requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

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

1.2 NHS Framework

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

(2) The Code of Accountability for NHS Boards (DH, revised April 2013) requires that, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Code of Conduct makes various requirements concerning possible conflicts of interest of Board members.

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

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any

of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). (See Section 1.8 and Appendix 2 of the Corporate Governance Framework Manual.) This document has effect as if incorporated into the Standing Orders. Delegated Powers are covered in a separate document entitled – 'Schedule of Matters reserved to the Board and Scheme of Delegation' and have effect as if incorporated into the Standing Orders and Standing Financial Instructions. The Standing Orders and Standing Financial Instructions will be reviewed annually

1.4 Integrated Governance

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

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

In accordance with the Membership, Procedure and Administration Arrangements regulations the composition of the Board shall be:

(1) The Chair of the Trust (Appointed by NHS Improvement);

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

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

- the Chief Executive;
- the Director of Finance

The Trust shall have not more than 11 and not less than 8 members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

2.2 Appointment of the Trust's Chair and Members of the Trust

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

2.3 Terms of Office of the Chair and Members

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

2.4 Appointment and Powers of Vice-Chair

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

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

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

2.5 Joint Members

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

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

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

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

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

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

2.6 Patient and Public Involvement

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

2.7 Role of Members

The Board will function as a corporate decision-making body, Officer and Non-Officer Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) **Executive Members**

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) **Chief Executive**

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

(3) **Director of Finance**

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

(4) **Non-Executive Members**

The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(5) **Chair**

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

The Chair shall liaise with the NHS Improvement - Appointments over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

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

2.8 Corporate role of the Board

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

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

(3) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 3.

(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 l (2) or Section l (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press (see Standing Order 3.17).

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

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

3.8 Motion to Rescind a Resolution

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

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

3.9 Chair of meeting

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

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

3.10 Chair's ruling

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

3.11 Quorum

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

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

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

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

3.12 Voting

(i) Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chair of the meeting) shall have a second, and casting vote.

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

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

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

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

(vi) A manager who has been formally appointed to act up for an Officer Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Officer Member.

(vii) A manager attending the Trust Board meeting to represent an Officer Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member. An Officer's status when attending a meeting shall be recorded in the minutes.

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

3.13 Suspension of Standing Orders

(i) Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Officer Member of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

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

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

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

3.14 Variation and amendment of Standing Orders

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

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

3.15 Record of Attendance

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

3.16 Minutes

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

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

3.17 Admission of public and the press

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

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

- 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act l960

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

(ii) **General disturbances**

The Chair (or Vice-Chair if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

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

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

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

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

(iv) **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

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

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 relevant sub-committee.

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

4.8.2 **Remuneration and Appointments Committee ~~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 and Appointments Committee will be established and constituted.

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

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

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

~~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)~~(iv) ~~to review and approve the Remunerations Framework for subsidiary companies of the Trust.~~

Formatted: Indent: Left: 1.53 cm, Hanging: 0.72 cm

4.8.3 **Charitable Trustee Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Trust Board will establish a Trust and Charitable Trust Committee to administer those funds in accordance with any

statutory or other legal requirements or best practice required by the Charities Commission.

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

4.8.4 **Other Committees**

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

These currently include:

i) Finance, Performance and People Committee - .
The purpose of the Finance, Performance and People Committee is to provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and workforce 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;
- overseeing risk management for the duties of the Committee.

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

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 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.

Comment [JM1]: Note: There may be minor updates for this section subject to the QSC TOR review (due Oct 21)

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

iii) Auditor Panel - In line with the requirements of the Local Audit and Accountability Act 2014 the Trust has established an Auditor Panel to enable the Trust to meet its statutory duties by advising on the selection, appointment and removal of the External Auditors and on maintaining an independent relationship with them. The Terms of Reference are approved by the Trust Board and reviewed on a periodic basis. The committee is comprised of the Audit Committee Non-Executive Directors.

iii) Strategy Committee
The Strategy Committee is responsible for overseeing the delivery of the Trust's vision and strategic aims to 2024 and associated transformation of services. To provide Board level assurance of the leadership, commitment and alignment of

corporate strategies, strategic projects and service and workforce transformation agreed under the scope of the committee.

iv) Equality and Inclusion Committee

The purpose of the Equality and Inclusion Committee (EIC) is to provide assurance to the Board that appropriate arrangements are in place to improve equity and inclusion for our patients and people. Through this work the Committee will play a key role in ensuring the Trust delivers sustainable improvements.

Formatted: Indent: First line: 0 cm

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 The National Health Service Act 2006 as amended by the Health and Social Care Act 2012 allows for regulations to provide for the functions of Trusts to be carried out by third parties. In accordance with The Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 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 Conflicts of Interest Policy.

7.1.2 **Interests which are relevant and material**

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

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

Formatted: Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Left + Aligned at: 1.59 cm + Indent at: 2.86 cm

Formatted: Not Expanded by / Condensed by

Formatted: Normal, Indent: Left: 2.86 cm, Hyphenate, Tab stops: Not at -2.54 cm + -1.27 cm + 0 cm + 1.59 cm + 2.54 cm + 2.73 cm + 3.81 cm

- Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with East and North Hertfordshire NHS Trust, including but not limited to lenders or banks.

~~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~~

Formatted: Tab stops: Not at 2.73 cm

Formatted: Indent: Left: 0 cm, Hanging: 3.81 cm, No bullets or numbering, Tab stops: 3.81 cm, Left + Not at 2.73 cm

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

7.1.3 **Advice on Interests**

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

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

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

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

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

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

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

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

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

7.2 Register of Interests

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

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

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

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

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

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

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

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

(iii) "Pecuniary interest"

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

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

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

iv) Exception to Pecuniary interests

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

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

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

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

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

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

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

(ii) The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health

Service that the disability should be removed. (See SO 7.3.3 on the 'Waiver' which has been approved by the Secretary of State for Health).

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

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

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

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

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

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

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

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

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

(b) at a meeting of a Committee –

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

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

(3) Application of waiver

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

It will apply to:

(i) A member of the East and North Hertfordshire NHS Trust ("the Trust"), who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

(a) services under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation; or

(b) services in connection with a pilot scheme under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation;

for the benefit of persons for whom the Trust is responsible.

(ii) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:-

(a) arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(b) has been declared by the relevant Chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:–

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

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

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

The removal is subject to the following conditions:

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

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

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

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

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

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

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

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

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

7.4 Standards of Business Conduct

7.4.1 Trust Policy and National Guidance

All Trust staff and members of must comply with the Trust's Values and Standards of Business Conduct and Managing Conflicts of Interest Policy and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff' (see SO 6.2).

7.4.2 Interest of Officers in Contracts

i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any

person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust's Trust Secretary as soon as practicable.

ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 **Canvassing of and Recommendations by Members in Relation to Appointments**

i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4.4 **Relatives of Members or Officers**

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

ii) The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

iii) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' (SO 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 **Custody of Seal**

The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him/her in a secure place.

8.2 **Sealing of Documents**

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

8.3 **Register of Sealing**

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 **Signature of documents**

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

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

9. MISCELLANEOUS (see overlap with SFI No. 21.3)

9.1 **Joint Finance Arrangements**

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation.

See overlap with Standing Financial Instruction No. 21.3.

SECTION C - SCHEME OF RESERVATION AND DELEGATION

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
NA	THE BOARD	***Regulations and Control*** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 5.2 5. Approve a scheme of delegation of powers from the Board to committees**.** 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		Executive's attention in accordance with SO 5.6. 16. Discipline members of the Board or employees who are in breach of statutory requirements or SOs. 17. Approve the establishment of a subsidiary company and the associated articles of association and operating framework
NA	THE BOARD	**Appointments/ Dismissal** 1. Appoint the Vice Chair of the Board. 2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2). 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders). 6. Approve proposals of the Remuneration Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration Committee.
NA	THE BOARD	***Strategy, Plans and Budgets*** 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment. 5. Approve budgets. 6. Approve annually Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a 3 year period or the period of the contract if longer. 11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		12. Approve individual compensation payments. 13. Approve proposals for action on litigation against or on behalf of the Trust. Review use of NHSLA risk pooling schemes (LPST/CNST/RPST).
	THE BOARD	**Policy Determination** 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. Policies so adopted shall be listed and held by the Trust Secretary
	THE BOARD	**Audit** 1 Receipt of the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 2 Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
NA	THE BOARD	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for funds held on trust.
NA	THE BOARD	**Monitoring** 1. Receipt of such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board. 3. Receive reports from DoF on financial performance. 4. Receive reports from the Chie Executive on performance matters by exception.

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. ~~3.~~4. Review the work and findings of the external auditors and consider the implications and management's responses to their work. 5. The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. 6 Monitor compliance with Standing Orders and Standing Financial Instructions; 7 Review schedules of losses and compensations and making recommendations to the Board. 8 Review the annual financial statements prior to submission to the Board. A full list of responsibilities can be viewed in the Terms of reference for this committee which are appended to this document
SFI 20.1.2	REMUNERATION AND ~~TERMS OF SERVICE~~APPOINTMENTS COMMITTEE (REMUNERATION COMMITTEE)	The Committee will ~~:~~make recommendations to the Board on the remuneration and terms of service for the Chief Executive and other Executive Directors and those staff that are not covered by Agenda for Change or Medical and Dental Terms and Conditions; to monitor and evaluate the performance of Executive Directors and to oversee contractual arrangements, including proper calculation and scrutiny of termination payments. The Committee will also review and approve the Remunerations Framework for subsidiary companies of the Trust.

Formatted: English (U.K.), Condensed by 0.1 pt

Formatted: Indent: Left: 0 cm, First line: 0 cm, Tab stops: Not at 1.75 cm

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		~~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 - 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.. The Committee will be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the Trust's Clinical Strategy 2019-2024 and Quality Strategy. Please note the Trust's Audit Committee will ensure the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk and the Finance, Performance and People Committee will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances QSC will

Comment [JM2]: Note: There may be minor updates for this section subject to the QSC TOR review (due Oct 21)

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		provide scrutiny. A full list of responsibilities can be viewed in the Terms of reference for the committee which are appended to this document
	FINANCE, PERFORMANCE AND PEOPLE COMMITTEE	The purpose of the Finance, Performance and People Committee is to provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and workforce 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; • overseeing risk management for the duties of the Committee. The Committee shall be kept informed of any developments relating to the Hertfordshire and West Essex Integrated Care System that may impact on the work of the Committee. 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

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		which impact on these, in accordance with the Trust overall vision, values and business strategy. • to manage and monitor clinical quality, finance performance and activity. It will ensure executive decision-making and sign-up to delivery through group and personal accountability. The EC will act in the context of corporate governance and the Trust Board can be assured that relevant issues will be aired, whether or not decisions are taken by the EC and reported to the Board or recommendations are formulated by the EC and made by the Board. A full list of responsibilities can be viewed in the Terms of reference for the committee
	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.
	EQUALITY AND INCLUSION	The purpose of the Equality and Inclusion Committee (EIC) is to provide assurance to the Board that appropriate arrangements are in place to improve equity and inclusion for our patients and people. Through this work the Committee will play a key role in ensuring the Trust delivers sustainable

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	COMMITTEE	improvements. A full list of responsibilities can viewed in the Terms of Reference for the Committee.
	AUDITOR PANEL	In line with the requirements of the Local Audit and Accountability Act 2014 the Trust has established an Auditor Panel to enable the Trust to meet its statutory duties by advising on the selection, appointment and removal of the External Auditors and on maintaining an independent relationship with them. The Auditor Panel will be reinstated when the contract requires review. The Terms of Reference are approved by the Trust Board and reviewed on a periodic basis. The committee is comprised of the Audit Committee Non-Executive Directors. A full list of responsibilities can be viewed in the Terms of reference for the committee.

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

REF	DELEGATED TO	DUTIES DELEGATED
1 & 5	**CHIEF EXECUTIVE & TRUST SECRETARY**	**Review scheme of delegation**
7	CHIEF EXECUTIVE (CE)	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
9	CE AND DIRECTOR OF FINANCE (DOF)	Ensure the accounts of the Trust are prepared under principles and in a format directed by the SofS. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
10	CHIEF EXECUTIVE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer.

REF	DELEGATED TO	DUTIES DELEGATED
		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).
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

REF	DELEGATED TO	DUTIES DELEGATED
		his/her advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CE should inform the NHSI and the DH. In such cases, and in those described in paragraph 24, the CE should as a member of the Board vote against the course of action rather than merely abstain from voting.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.1.7	BOARD	Approve procedure for declaration of hospitality and sponsorship.
1.3.1.8	BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
1.31.9 & 1.3.2.2	ALL BOARD MEMBERS	Subscribe to Code of Conduct, Trust Values and coaching culture.
1.3.2.4	BOARD	Board members share corporate responsibility for all decisions of the Board.
1.3.2.4	CHAIR AND NON EXECUTIVE/OFFICER MEMBERS	Chair and non-officer members are responsible for monitoring the executive management of the organisation and are responsible to the SofS for the discharge of those responsibilities.
1.3.2.4	BOARD	The Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.24	BOARD	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these, 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; 4. establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.
1.3.2.5	CHAIR	It is the Chair's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board; 7. advise the Secretary of State on the performance of Non-Executive Board members.

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.2.5	CHIEF EXECUTIVE	The Chief Executive is accountable to the Chair and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
1.3.2.6	NON EXECUTIVE DIRECTORS	Non-Executive Directors are appointed by NHSI – Appointments to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
1.3.2.8	CHAIR AND DIRECTORS	Declaration of conflict of interests.
1.3.2.9	BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SCHEME OF DELEGATION FROM STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	CHAIR	Final authority in interpretation of Standing Orders (SOs).
2.4	BOARD	Appointment of Vice Chair
3.1	CHAIR	Call meetings.
3.9	CHAIR	Chair all Board meetings and associated responsibilities.
3.10	CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIR	Having a second or casting vote
3.13	BOARD	Suspension of Standing Orders
3.13	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.14	BOARD	Variation or amendment of Standing Orders
4.1	BOARD	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Chief Executive.)
5.2	CHAIR & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	THE BOARD	Declare relevant and material interests.
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
7.4	ALL STAFF	Comply with national guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff" and Trust Values.
7.4	ALL	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
8.1/8.3	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
8.4	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	DIRECTOR OF FINANCE	Approval of all financial procedures.
10.1.4	DIRECTOR OF FINANCE	Advice on interpretation or application of SFIs.
10.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
10.2.3	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.3	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.4	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.5	DIRECTOR OF FINANCE	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and staff; e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
10.2.7	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.2.8	DIRECTOR OF FINANCE	All members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.
11.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
11.1.2	CHAIR	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 & 11.2.1	DIRECTOR OF FINANCE	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
11.2.1	DIRECTOR OF FINANCE	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
11.3	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with Public Sector Internal Audit Standards and best practice.
11.4	AUDIT COMMITTEE	Ensure cost-effective External Audit.
11.5	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist/Anti-Crime Specialist.
11.6	CHIEF EXECUTIVE	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
13.1.1	CHIEF EXECUTIVE	Compile and submit to the Board a delivery plan which takes into account financial targets and forecast limits of available resources. The plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
13.1.2 & 13.1.3	DIRECTOR OF FINANCE	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
13.1.4	BUDGET HOLDERS	All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
13.1.5	BUDGET HOLDERS	All budget holders will sign up to their allocated budgets at the commencement of each financial year.
13.1.6	DIRECTOR OF FINANCE	Ensure adequate training is delivered on an on going basis to budget holders.
13.3.1	CHIEF EXECUTIVE	Delegate budget to budget holders.
13.3.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
13.4.1	DIRECTOR OF FINANCE	Devise and maintain systems of budgetary control.
13.4.2	BUDGET HOLDERS	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment.
13.4.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the Annual Plan.
13.6.1	CHIEF EXECUTIVE	Submit monitoring returns
14.1	DIRECTOR OF FINANCE	Preparation of annual accounts and reports.
15.1	DIRECTOR OF FINANCE	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
16.	DIRECTOR OF FINANCE	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
16.2.3	ALL EMPLOYEES	Duty to inform DoF of money due from transactions which they initiate/deal with.
17.	CHIEF EXECUTIVE	Tendering and contract procedure.
17.5.3	CHIEF EXECUTIVE	Waive formal tendering procedures.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.5.3	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Board.
17.5.5	DIRECTOR OF FINANCE	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.
17.6.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders received.
17.6.3	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations despatched.
17.6.4	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Where one tender is received will assess for value for money and fair price.
17.6.6	CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.6.8	CHIEF EXECUTIVE	Will appoint a manager to maintain a list of approved firms.
17.6.9	CHIEF EXECUTIVE	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
17.7.2	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
17.7.4	CHIEF EXECUTIVE or DIRECTOR OF FINANCE	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.10	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
17.10	BOARD	All PFI proposals must be agreed by the Board.
17.11	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.12	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
17.15	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
17.15.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
18.1.1	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
18.3	CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA
20.1.1	BOARD	Establish a Remuneration & Terms of Service Committee
20.1.2	REMUNERATION COMMITTEE	Advise the Board on and make recommendations on the remuneration and terms of service of the CE, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
20.1.3	REMUNERATION COMMITTEE	Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.
20.1.4	BOARD	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
20.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
20.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.4.1 and 20.4.2	DIRECTOR OF FINANCE	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 10.4.2).
20.4.3	NOMINATED MANAGERS*	Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time.
20.4.4	DIRECTOR OF FINANCE	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
20.5	NOMINATED MANAGER*	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
21.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. Authorised signatory list is maintained by the finance Department and available on request
21.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
21.2.1	REQUISITIONER*	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
21.2.2	DIRECTOR OF FINANCE	Shall be responsible for the prompt payment of accounts and claims.
21.2.3	DIRECTOR OF FINANCE	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
21.2.4	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
21.2.4	DIRECTOR OF FINANCE	Approve proposed prepayment arrangements.
21.2.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform DoF if problems are encountered).
21.2.5	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
21.2.6	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
21.2.7	CHIEF EXECUTIVE DIRECTOR OF FINANCE	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
21.3	DIRECTOR OF FINANCE	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
22.1.1	DIRECTOR OF FINANCE	The DoF will advise the Board on the Trust's ability to pay dividend on PDC and report, periodically, concerning the PDC debt and all loans and overdrafts.
22.1.1	BOARD	Will approve the Trust's plans for applications for short-term or longer-term borrowings and loans
22.1.2	BOARD	Approve a list of employees authorised to make applications and sign loan documentation on behalf of the Trust. (This must include the CE and DoF.)

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
22.1.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
22.1.4	CHIEF EXECUTIVE OR DIRECTOR OF FINANCE	Be on an authorising panel comprising at least one other member for loan and borrowing application and documentation submission..
22.2.2	DIRECTOR OF FINANCE	Will advise the Board on investments and report, periodically, on performance of same.
22.2.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions on the operation of investments held.
23	DIRECTOR OF FINANCE	Ensure that Board members are aware of the Financial Framework and ensure compliance
24.1.1 & 2	CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.
24.1.2	DIRECTOR OF FINANCE	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
24.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
24.1.4	DIRECTOR OF FINANCE	Assess the requirement for the operation of the construction industry taxation deduction scheme.
24.1.5	DIRECTOR OF FINANCE	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
24.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
24.1.7	DIRECTOR OF FINANCE	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
24.2.1	DIRECTOR OF FINANCE	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
24.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.
24.3.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from DoF).
24.3.5	DIRECTOR OF FINANCE	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
24.3.8	DIRECTOR OF FINANCE	Calculate and pay capital charges in accordance with Department of Health requirements.
24.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
24.4.2	DIRECTOR OF FINANCE	Approval of fixed asset control procedures.
24.4.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
25.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
25.2	DIRECTOR OF FINANCE	Responsible for systems of control over stores and receipt of goods.
25.2	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks
25.2	DESIGNATED ESTATES OFFICER	Responsible for control of stocks of fuel oil and coal.
25.2	NOMINATED OFFICERS*	Security arrangements and custody of keys
25.2	DIRECTOR OF FINANCE	Set out procedures and systems to regulate the stores.
25.2	DIRECTOR OF FINANCE	Agree stocktaking arrangements.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
25.2	DIRECTOR OF FINANCE	Approve alternative arrangements where a complete system of stores control is not justified.
25.2	DIRECTOR OF FINANCE	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
25.2	NOMINATED OFFICERS*	Operate system for slow moving and obsolete stock, and report to DoF evidence of significant overstocking.
25.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supply Chain.
26.1.1	DIRECTOR OF FINANCE	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
26.2.1	DIRECTOR OF FINANCE	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
26.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and DoF.
26.2.2	DIRECTOR OF FINANCE	Where a criminal offence is suspected, DoF must inform the police if theft or arson is involved. In cases of fraud and corruption DoF must inform the relevant LCFS/ACS, and NHS Counter Fraud Authority NHS requirements underpinned by the Government Counter Fraud Functional Standards. ~~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 NHS Requirements in accordance with the Government Counter Fraud Functional Standards. ~~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) / Anti-Crime Specialist (ACS) and NHS Counter Fraud Authority in cases of fraud, bribery 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, 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 requirements in accordance with the Government Counter Fraud Functional Standards ~~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) / Anti-Crime Specialist (ACS) 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 requirements in accordance with the Government Counter Fraud Functional Standards.~~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 Government Counter Fraud Functional Standards ~~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/ACS 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.

11.6 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~~ Hertfordshire and West Essex ICS NHS Procurement Services 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~~ Hertfordshire and West Essex ICS NHS Procurement Services 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~~ 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.~~

For public procurements commenced and not completed before 31 December 2020, 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.

For public procurement commenced after 1 January 2021, the World Trade Organisation's (WTO) Government Procurement Agreement (GPA) 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~~Atamis
~~(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.

(v) Where a feasibility study is required this must be conducted by an independent agency; in common with all procurements a tender should be issued with the Trust's exact requirements to potential bidders to enable them to produce a design with the associated costs, thus giving all potential bidders a fair and level platform with which to submit their bids for the tender.

~~(iv)~~

Formatted: List Paragraph, Left, No bullets or numbering, Hyphenate, Tab stops: Not at -1.27 cm + 1.27 cm + 1.52 cm + 1.9 cm

Formatted: Indent: Left: 2.8 cm, No bullets or numbering

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~~Atamis.

(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~~Atamis 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~~Hertfordshire and West Essex ICS NHS Procurement Services) as guardian for the ~~Bravo~~ Atamis 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~~Hertfordshire and West Essex ICS NHS Procurement Services) may request the Chief Executive to 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)~~(vi) 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.

Formatted: Indent: Left: 1.9 cm, No bullets or numbering

Formatted: Indent: Left: 0 cm, Hanging: 1.75 cm, No bullets or numbering

(vi) The Director of Procurement (~~Hertfordshire NHS Procurement~~Hertfordshire and West Essex ICS Procurement Services) 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~~ any relevant 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~~4.8.2)

20.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and ~~Terms of Service~~ Appointments Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

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

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

~~:~~

~~(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~~

Formatted: Indent: Left: 0 cm, Hanging: 1.59 cm

Formatted: Indent: Hanging: 1.59 cm

Formatted: Justified, Indent: Left: 0 cm, Hanging: 1.59 cm, Tab stops: Not at 3.17 cm

Formatted: Indent: Hanging: 1.59 cm, Tab stops: Not at 3.17 cm

Formatted: Justified, Indent: Hanging: 1.59 cm, Tab stops: Not at 3.17 cm

Formatted: Indent: Hanging: 1.59 cm, Tab stops: Not at 3.17 cm

Formatted: Justified, Indent: Left: 0 cm, Hanging: 1.59 cm, Tab stops: Not at 3.17 cm

Formatted: Indent: Left: 0 cm, Hanging: 1.59 cm

Formatted: Indent: Left: 0 cm, Hanging: 1.59 cm, Right: 0 cm, No bullets or numbering, Tab stops: 2.54 cm, Left + Not at 14.66 cm

Formatted: Indent: Left: 0 cm, Hanging: 1.59 cm

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 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 FPPC;

(c) Sets the capital budgets following approval by 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 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 Lifecycle unless the Finance, 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, 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 Deputy 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 Deputy 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, 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, 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/ACS -who will

decide, in consultation with the Director of Finance. 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~~122,976) 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~~Atamis system and a register of tenders maintained by the Board Secretary.

Contract or purchase over OJEU limit (currently £~~118,113~~ 122,976)

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 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	Director of Finance	

	£1,000,001pa and £5,000,000	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	Unchanged

		Director of Corporate area	
	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	Unchanged
	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 £10,001 and up to £50,000	Divisional Director/Assistant Director of Corporate area	Unchanged
	Over £5,000 and up to £10,000	General Manager, Divisional Nursing Service Manager, Head of Service	Unchanged
	Over £1,001 and up to £5,000	Departmental head / Budget Manager (Band 8 and above)	Unchanged
	Up to £1,000	Budget Manager (Band 7)	Unchanged
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	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 expenditure agreements	Up to £5,000	Charity Management Team (CMT)	Approved 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

East and North Hertfordshire NHS Trust

Agenda Item: 13.4

TRUST BOARD - PUBLIC SESSION – 3 NOVEMBER 2021
EQUALITY & INCLUSION COMMITTEE – MEETING HELD ON 12 OCTOBER 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present the report from the Equality and Inclusion Committee meeting on 12 October 2021 to the Board.		
Action required: For information		
Previously considered by: **N/A**		
Director: **Chair of Equality & Inclusion Committee**	**Presented by:** **Chair of Equality & Inclusion Committee**	**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) The discussions at the meeting reflect the BAF risks assigned to the Equality and Inclusion Committee.
Any other risk issues (quality, safety, financial, HR, legal, equality): N/A

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

EQUALITY AND INCLUSION COMMITTEE MEETING – 12 OCTOBER 2021
SUMMARY TO THE TRUST BOARD MEETING HELD ON 3 NOVEMBER 2021

The following Non-Executive Directors were present:
Biraj Parmar (Chair), Ellen Schroder (Trust Chair) and Bob Niven

Matters discussed:

EDI Dashboard
The Equality and Inclusion Committee reviewed the EDI Dashboard noting that it will continue to be developed over the year and allow for key metrics to be monitored on a regular basis in order to assess trends.

LGBTQ+ Deep Dive
The Equality and Inclusion Committee received an update from the Medical Director on recent work and activities undertaken by the LGBTQ+ network in his capacity as the executive lead for the LGBTQ+ network. Activities the network had been involved with included Herts Pride and the National Coming Out Day and Trans Visibility Day which had been successful events.

The Committee was pleased to hear of the momentum that was building behind the groups and discussed the prospect of developing more robust forward plans and objectives to help with measuring outcomes.

It was agreed that the Trust Chair would organise for a Non-Executive Director to be assigned to each of the five network groups and it was noted that involvement by senior members of staff is always appreciated.

Gender Pay Gap
The Equality and Inclusion Committee held a detailed discussion regarding the gender pay gap, using the data from the 2020 submission as a starting point and noting the areas of greatest variation.

The Committee also discussed the gender pay gap in relation to the Clinical Excellence Awards and considered how to ensure the process was as objective and representative of the workforce as possible. It was agreed there would be a further discussion in this regard at the next meeting.

Model Employer Deep Dive
The Equality and Inclusion Committee discussed the WRES 'model employer' targets and current position covering 2018 to 2028. Most bands have shown increased representation from black, Asian and minority ethnic staff but there are certain Agenda for Change bandings, mostly at a more senior level, where the targets have not been met. Initiatives are in place to support the development of staff into these roles. The Committee discussed the use of one such initiative, the inclusion ambassadors, and how the impact can be measured.

People Culture
The Equality and Inclusion Committee received an update on the culture work taking place in the Trust. This included a rolling programme of conversations between different groups and cross-sections of staff to increase understanding, empathy and to promote better relations amongst the workforce. The programme would begin with the national reciprocal mentoring programme involving minority ethnic staff and senior leaders.

The Committee was also informed of plans in relation to expanding the Freedom to Speak Up provision and expressed their desire for staff to feel psychologically safe to raise concerns.

Population Health Management Update

The Committee received the Population Health Management update regarding the data analysis that would enable identification of outlier groups in terms of access to healthcare and building targeted interventions. The Committee received a presentation on the development of a virtual CKD clinical, an area that the data had identified as likely to benefit from a focused approach to improve health outcomes.

A population health working group has been set up. The Committee agreed the oversight in relation to equality and inclusion of access in relation to population health management should be via the Equality and Inclusion Committee, and the transformational element would be overseen by the Transformation Delivery Oversight Group.

Biraj Parmar
Equality & Inclusion Committee Chair
October 2021

East and North Hertfordshire NHS Trust

Agenda Item: 13.5

TRUST BOARD - PUBLIC SESSION – 3 NOVEMBER 2021

STRATEGY COMMITTEE – 21 SEPTEMBER 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Strategy Committee meeting held on 21 September 2021. The report includes details of any decisions made by the Strategy Committee under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of Strategy Committee	**Presented by:** Chair of Strategy Committee	**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) The discussions at the meetings reflect the BAF risks assigned to the Strategy Committee.
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

STRATEGY COMMITTEE – 21 SEPTEMBER 2021

EXECUTIVE SUMMARY REPORT TO TRUST BOARD

The following Non-executive Directors were present:
Karen McConnell (Strategy Committee Chair), Biraj Parmar (Associate Non-Executive Director), Ellen Schroder (Trust Chair) (for part of the meeting) and Jonathan Silver (Non-Executive Director).

The following core attendees were present:
Nick Carver (Chief Executive), Martin Armstrong (Director of Finance and Deputy CEO), Michael Chilvers (Medical Director), Kevin O'Hart (Director of Improvement), Kevin Howell (Director of Estates and Facilities), Thomas Pounds (Chief People Officer), Rachael Corser (Director of Nursing), Mary Hartley (Deputy Director of Strategy)

MATTERS TO BE REFERRED TO THE BOARD
No specific issues were referred to the Board.

MATTERS CONSIDERED BY THE COMMITTEE:

STRATEGIC PLANNING FRAMEWORK
The Committee received an update on the progress with the strategic planning framework refresh over the last 3 months. This reflected progress on the executive level review of the vision and strategic objectives to date and considerations in relation to service prioritisation. Work had also been undertaken on the development of baseline models for the enabling strategies which would allow identification of key constraints and help the Trust understand the consequences of any decisions made. The next steps leading to a draft integrated Business Plan were outlined including appropriate stakeholder and patient engagement.

ENABLING STRATEGIES:
UPDATED GREEN PLAN
The Committee received the updated Green Plan. The sustainability group had scrutinised the plan, the basis of which was set around national guidance. Following discussion as to whether the targets were realistic and achievable, it was agreed that the Executive Team would review the key targets and actions of the Green Plan and revert to the November Strategy Committee before taking the updated Green Plan to the Board for final approval.

ROBOTICS STRATEGY
The Strategy Committee received and noted an update on the current surgical robotics programme and proposed future development. The Committee was supportive of exploring this area further and noted the importance of ensuring this was in alignment with other strategic developments.

CANCER STRATEGY UPDATE
The Strategy Committee received and noted an update on the development of the cancer strategy including the interface of the cancer strategy with the ongoing Strategy Refresh and the proposals in relation to Mount Vernon. More work needed to be undertaken on developing measures of success, stakeholder engagement and population health dynamics to ensure the strategy responded to the needs of the organisation and surrounding population.

STRATEGIC PROJECTS:
MVCC SERVICE RE-PROVISION AND NETWORKED RADIOTHERAPY UPDATE
The Strategy Committee noted the overview provided regarding the MVCC Service re-provision and the development of the proposal for networked radiology. The overall status report rating was currently amber.

ICS PATHOLOGY PROCUREMENT
The Committee noted the update regarding the ICS Pathology Procurement. The project was now ready to proceed to Best and Final offer (BAFO) and the final business case would be brought to the Trust Board in early 2022 for approval and sign off.

VASCULAR BUSINESS CASE UPDATE
The Committee was informed that following review of the OBC and the resolution of outstanding financial issues, the FBC would be taken to the next Finance, Performance and People Committee as the next stage in the sign off process. The Committee agreed that as this was no longer a strategy item, it would not be brought to future Strategy Committee meetings.

SYSTEM COLLABORATION
Discussion on this item was deferred to the Trust Board. The Committee agreed that consideration would be given as to whether this item would be considered at the Trust Board rather than the Strategy Committee in the future.

ENHANCED SERVICES DEVELOPMENT UPDATE
The Strategy Committee discussed the report which outlined the background of the work the Trust was undertaking with HCT in relation to enhanced services including long prevention of admission, COVID services, virtual hospital and discharge home to assess. The development of the Enhanced Services Steering Group and its key areas of focus were noted.

UNIVERSITY HOSPITAL STATUS
The Committee received the report and was informed that the Trust had applied for University Hospital status but due to a recent change in the rules no longer fulfilled the criteria. Consideration was given to pursuing Teaching Hospital status and continuing the close relationship with the University of Hertfordshire.

ENHT ANNUAL OBJECTIVES
The Strategy Committee received and noted the ENHT annual objectives which had been agreed by the Board.

BOARD ASSURANCE FRAMEWORK
The Strategy Committee reviewed the latest version of the Board Assurance Framework and the risks that had been assigned to that Committee. It was noted that the Board Assurance Framework was aligned with the ENHT annual objectives. Since the Strategy Committee last met, risk 11 (MVCC) had increased to 16 and a deep dive had been conducted at the Audit Committee meeting in July to consider this risk.

Karen McConnell
Strategy Committee Chair

November 2021

East and North Hertfordshire NHS Trust

Agenda Item: 13.6

TRUST BOARD – 3 NOVEMBER 2021
CHARITY TRUSTEE COMMITTEE – MEETING HELD 13 SEPTEMBER 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board **in its capacity as Corporate Trustee** the summary report from the Charity Trustee Committee (CTC) meeting held on 13 September 2021.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of CTC	**Presented by:** Chair of CTC	**Author:** Trust Secretary

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality: our sites	To deliver high quality, compassionate services, consistently across all	☒
People: develops an	To create an environment which retains staff, recruits the best and engaged, flexible and skilled workforce	☒
Pathways: patient	To develop pathways across care boundaries, where this delivers best care	☒
Ease of Use: simple and staff	To redesign and invest in our systems and processes to provide a reliable experience for our patients, their referrers, and our	☒
Sustainability: clinically sustainable in	To provide a portfolio of services that is financially and 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 13 SEPTEMBER 2021

SUMMARY REPORT TO BOARD

The following members were present: Bob Niven (CTC Chair), Val Moore (Non-Executive Director) and David Buckle (Non-Executive Director)

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
To remodel the kitchen on the stroke unit to allow accessible therapy.	Approx £58,000	£12,000 to be used from the stroke fund with additional fundraising required. Clear costing to be obtained before fundraising commenced.
To purchase training equipment for maternity.	£23,914 plus VAT	£3,000 already put aside with the final amount to come from general funds.
To fund a member of staff (0.2 WTE) to evaluate AI algorithms which outline organs at risk for complex cancer patients.	£13,000	Not approved at this meeting. Discussion to be held with IT to see if resource is already available to support.
To recruit a replacement retirement Band 5 therapist at LJMC on a 1 year fixed term post to Sept 2022, increasing the hours from 6 hours p/w to 11 hours p/w	£3,120 plus £5,200	Approved.
To purchase Redirooms to enable infectious patients to be quickly and easily isolated without the need to move into a side room	TBA based on discussion with ops teams	Not approved at this meeting. A case to be made for the number requested and more information to be provided on safety compliance. Final decision was made in correspondence, to purchase four Redirooms (cost £83,400)
To cover the event budget to welcome HRH The Princess Royal to present the Queen's Award for Voluntary Service and celebrate the Butterfly volunteers.	£12,659	Approved.
To professionally create, design, publish and print 6,500 memory books which document the Covid-19 pandemic.	£57,600	Approved.
To staff the LIFE Gallery for another year.	£6,800	Approved.

Other outcomes:

Investment Portfolio Update

The advisors from Rathbones, who had recently been awarded the contract to manage the Charity's investments for a further four year period initially, presented a report on the

Charity's investment portfolio and factors affecting its performance. The Trust's Charity portfolio return since 31 May 2021 was 6.1% which was ahead of the benchmark.

Charity Highlight Report

The CTC received the Charity Highlight Report. The Committee was informed that community income was down due to challenges during the pandemic including less community activity and lower visitor rates in the hospital. Actions taken to increase individual giving included a community lottery which was to be launched in October 2021 and a number of cash appeal mailings. The Charity enjoyed excellent press coverage in April/ May with 14 press releases sent out resulting in 24 articles published. The Committee also heard that the 2021 Christmas campaign would be "What matters to you at Christmas" and would be launched on 8 November.

Major Projects Update: The Sunshine Appeal

The Committee was informed of the latest developments around the Sunshine Appeal and some challenges that were being worked through with the original location being reconsidered.

Charity Finance Report

The Committee received the Finance Report. The Committee were informed that as at 31 July 2021 the income was £113k below budget as a direct result of the COVID impact on the ability of the Charity to carry out fund raising activities. Expenditure was in line with the plan and any variance was timing-related and would rectify in the coming months. To assist with managing the Charity's income position, a reforecast would be brought to the December 2021 meeting.

Charity Annual Report and Accounts (Draft)

The Committee received and approved the East and North Hertfordshire Hospitals' Charity Annual Report and Accounts 2020/21 which had been submitted in August to the external auditors. The independent auditor's report to the Corporate Trustee of East and North Hertfordshire NHS Trust Charitable Fund was awaited and would be circulated to CTC members via email upon receipt. The annual report and accounts and auditor's report would then be considered by the Audit Committee at its meeting on 19 October and Trust Board on 3 November.

Bob Niven
Chair of the Charity Trustee Committee
November 2021

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

Agenda item: 14

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO 3 NOVEMBER 2021

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date

Draft Board Annual Cycle 2021-22

Notes regarding the annual cycle:

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

Items	April 2021	5 May 2021	June 2021	7 Jul 2021	Aug 2021	1 Sept 2021	Oct 2021	3 Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Standing Items												
Chief Executive's Report		X		X		X		X		X		X
Integrated Performance Report		X		X		X		X		X		X
Board Assurance Framework		X		X		X		X		X		X
Data Pack		X		X		X		X		X		X
Patient Testimony (Part 1 where possible)		X		X		X		X		X		X
Employee relations (Part 2)		X		X		X		X		X		X
Operational and People Recovery		X		X		X		X		X		X
Board Committee Summary Reports												
Audit Committee Report		X		X				X				X
Charity Trustee Committee Report		X		X				X		X		
Finance, Performance and People Committee Report		X		X		X		X		X		X
Quality and Safety Committee Report		X		X		X		X		X		X
Strategy Committee		X		X				X		X		
Equality and Inclusion Committee				X		X		X		X		X
Strategy												
Annual Operating Plan and objectives *(subject to change as dependent on national timeline)TBC*				X								

Draft Board Annual Cycle 2021-22

Items	April 2021	5 May 2021	June 2021	7 Jul 2021	Aug 2021	1 Sept 2021	Oct 2021	3 Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
System Working (ICS and ICP) Updates		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update		X		X		X		X		X		X
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report – Approval Process		X										
Value for Money Report						X						
Audit Committee TOR and Annual Report								X				
Freedom to Speak Up								X *Deferred to Jan*				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 Jan*				
Finance, Performance and People Committee												
Finance Update (IPR)		X		X		X		X		X		X
FPPC TOR and Annual Report								X				

Draft Board Annual Cycle 2021-22

Items	April 2021	5 May 2021	June 2021	7 Jul 2021	Aug 2021	1 Sept 2021	Oct 2021	3 Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Equality and Diversity Annual Report and WRES *Note – Likely to move to Inclusion Committee*						X						
Gender Pay Gap Report *Note – Likely to move to Inclusion Committee*												X
Market Strategy Review - *TBC*												
Quality and Safety Committee												
Complaints, PALS and Patient Experience Report		X ***See April QSC***				X		X *Deferred to Jan*		X		
Safeguarding and L.D. Annual Report (Adult and Children)				X								
Staff Survey Results												X
Learning from Deaths		X		X				X		X		
Nursing Establishment Review				X						X		
Responsible Officer Annual Review								X				
Patient Safety and Incident Report (Part 2)		X		X				X				X
University Status Annual Report				X *Deferred to Sept*		X						
QSC TOR and Annual Review								X				
Strategy Committee												
Digital Strategy Update				X *Deferred*				X *Covered at Oct Board Dev.*				X

Draft Board Annual Cycle 2021-22

Items	April 2021	5 May 2021	June 2021	7 Jul 2021	Aug 2021	1 Sept 2021	Oct 2021	3 Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Strategy Committee TOR and Annual Review								**X** *Deferred to Jan*				
Shareholder / Formal Contracts												
ENH Pharma (Part 2)				**X** Received and discussed at 2 June Board Developme nt meeting								

DATA PACK

Contents

1. Performance Data:

CQC Outcomes Summary

2. Learning from Deaths Report

1. 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:

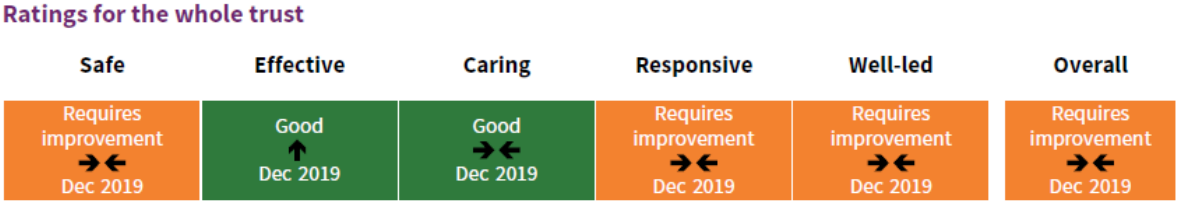
- Medicine (MVCC)
- Radiotherapy (MVCC)
- Outpatients

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



	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

East and North Hertfordshire NHS Trust

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

East and North Hertfordshire NHS Trust

QUALITY AND SAFETY COMMITTEE – September 2021
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: **Medical Director**		
Director: **Medical Director**	**Presented by:** **Medical Director**	**Author:** **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 report has been approved by the Mortality Surveillance Committee.

The transition from Dr Foster to CHKS as a reporting source has now been completed. 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 1.41% for the 12 month period to July 2021 compared to 1.25% for the latest 3 years.
HSMR: (data period Jun20 – May21)	HSMR for the 12 month period is **81.16, 'First quartile'.**
SHMI: (data period Mar20 – Feb21)	Headline SHMI for the 12 month period is **87.28 'lower than expected band 3'. One of only 13 Trusts of 123 in top band.**
HSMR – Peer comparison	ENHT is ranked 1st (out of 8) within the Model Hospital list* of peers.

* We are comparing our performance against the peer group indicated for ENHT in the Model Hospital (updated in 2021), rather than the purely geographical regional group we used to use. Further detail is provided in 2.2.3.

1.3 Headlines

- COVID-19 update
- HSMR has remained stable and is in the first quartile nationally
- SHMI is stable and remains in the 'better than expected' Band 3
- Medical Examiners – following the initial pilot full roll-out of the service began in May
- Mortality Review Tool/Datix iCloud: development work continues
- Regular on-going mortality monitoring via Mortality Surveillance Committee, Quality and Safety Committee and Board.

1.4 Current risks

Table 2 below summarises key risks identified:

Risks	Report ref (Mitigation)
COVID-19	2.1
Fractured Neck of Femur mortality	2.4.2
Stroke mortality	2.4.2
7 day service	2.6.1
Care bundles	2.6.2
Medical Examiner Introduction	2.6.3
Mortality Review – need for content/IT development	3.1
Mortality module incorporation onto Datix iCloud platform	3.1
Severe Mental Illness – Identification/flagging of patients	3.2.3

SECTION 2: MORTALITY PERFORMANCE

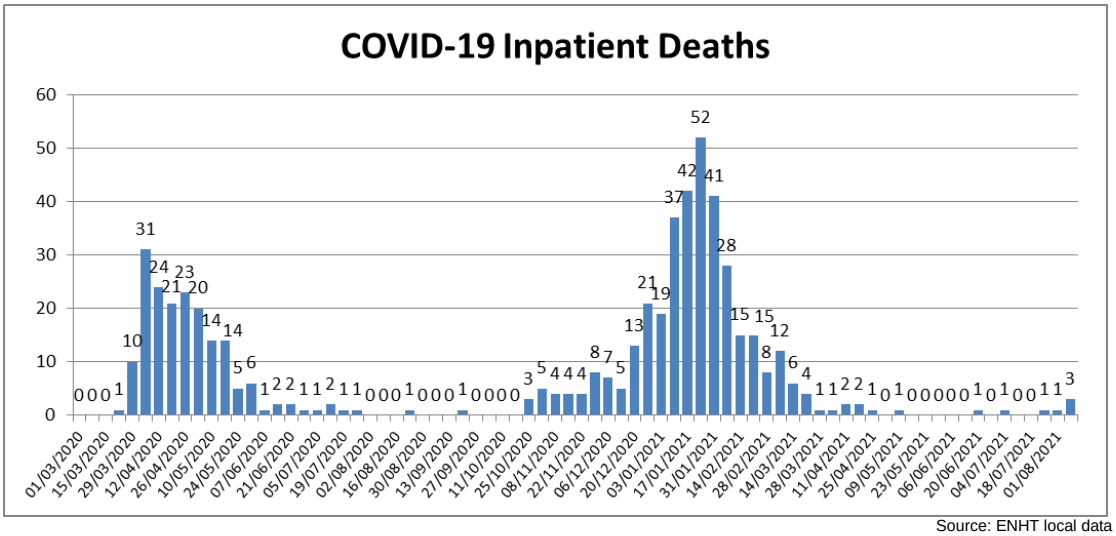
2.1 COVID-19 Update

2.1.1 COVID-19 mortality data

2.1.1.1 COVID in-patient deaths

The first COVID-19 death reported in the Trust occurred on 19 March 2020. Figure 1 shows subsequent deaths by week up to 8 August 2021. The dates shown are 'week-ending' dates. This chart shows our first local peak occurred week ending 5 April 2020. There have been far more deaths in the second wave, with the second peak occurring in week ending 24 January 2021. There has been a recent increase in the number of deaths at the trust. To date this does not compare to the first two waves but appears consistent with national picture.

Figure 1: Trust COVID-19 Inpatient deaths – 01/03/2020 to 08/08/2021 by Week



Source: ENHT local data

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

There were 550 COVID-19 Inpatient deaths at the trust from 01 March 2020 to 08 August 2021. This figure includes both patients who tested positive for COVID-19 and patients who had a clinical assessment of COVID-19.

2.1.1.2 COVID in-patient analysis

Figure 2 shows that the proportion of deaths by gender has remained unchanged when compared with in the previous report.

Figure 3 shows that our local findings regarding those patients worst impacted by the virus are broadly in line with nationally reported outcomes, namely; the elderly have been worst hit. In line with the national picture, in parallel to the vaccination programme, the average age has been seen to fall.

Fig 2: COVID-19 Inpatient deaths (01/03/20-08/08/21) by Gender

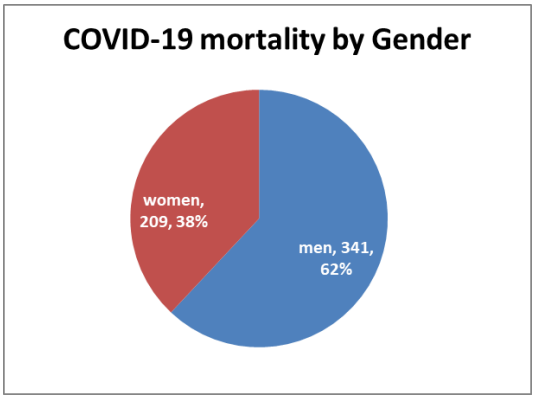
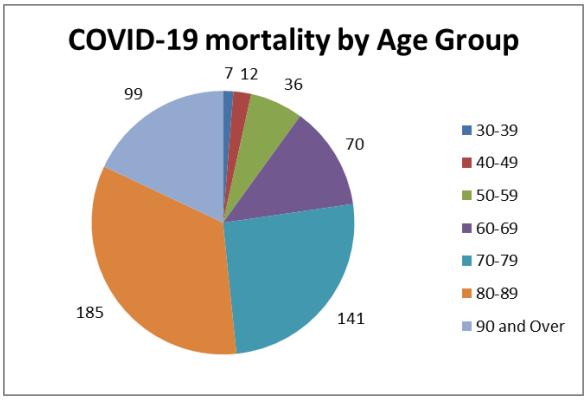


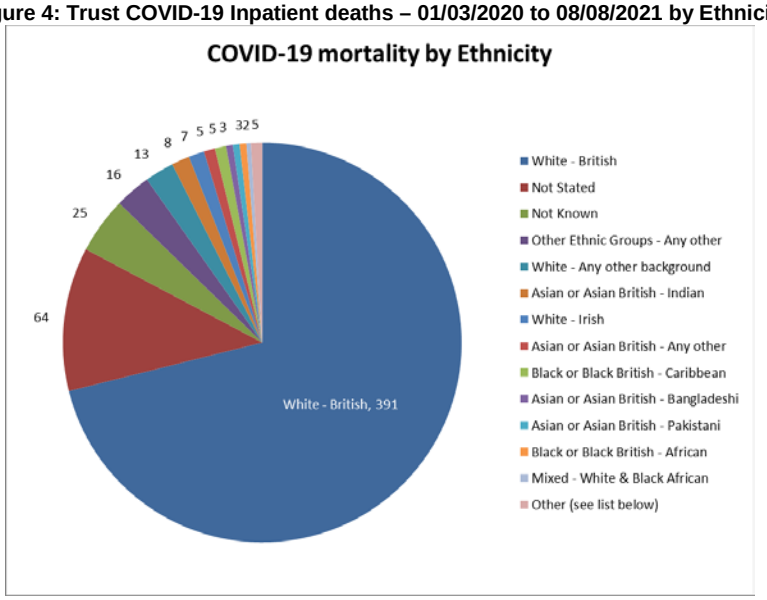
Fig 3: COVID-19 Inpatient deaths (01/03/20-08/08/21) by Age



Source: ENHT local data

Figure 4 does not demonstrate a bias towards the BAME population, but this may be a reflection of the demographics of the Hertfordshire region.

Figure 4: Trust COVID-19 Inpatient deaths – 01/03/2020 to 08/08/2021 by Ethnicity



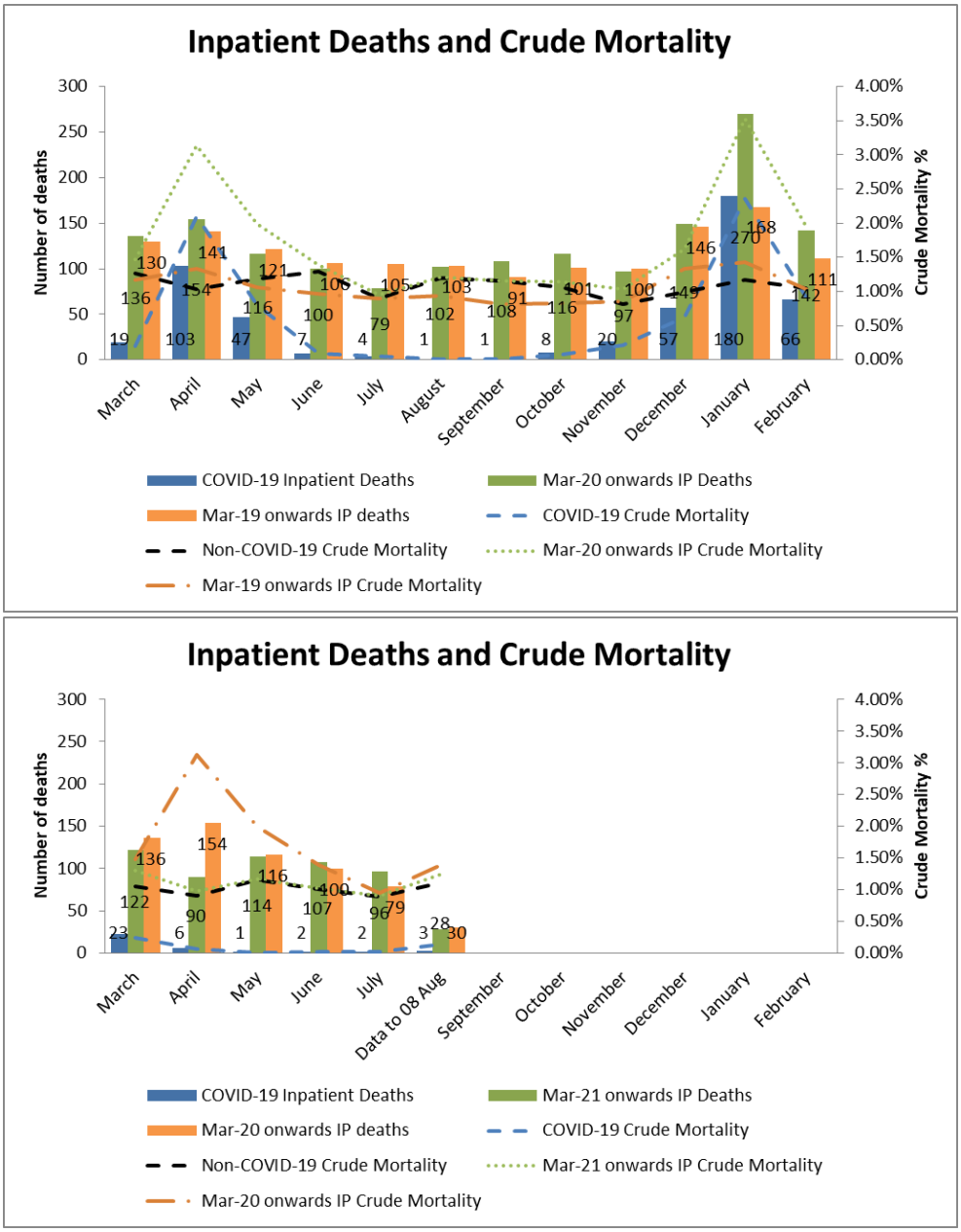
Source: ENHT local data

Note, the 5 deaths in "Other (see list below)" in Figure 4, are Black or Black British - Any other, Mixed - Any other mixed background, Mixed - White & Asian, Other Ethnic Groups – Chinese.

2.1.1.3 COVID in-patient deaths and crude mortality

Figure 5 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. The numbers of monthly COVID-19 deaths have been fairly low since April 2021, so the Non-COVID-19 Crude Mortality rates closely follows the IP Crude Mortality rates for these months. Although the numbers of in-patient deaths in June and July 2021 have been higher than June and July 2020 respectively, there has been more general activity in 2021 which is reflected in the crude mortality rates for these two 2021 months.

Figure 5: Trust COVID-19 In-patient deaths – 01/03/2020 to 08/08/2021 by Month



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

2.1.2 Potential indicators of performance

2.1.2.1 CHKS COVID Reporting

CHKS, our specialist healthcare intelligence provider, is currently working on a model which will enable us to better understand our COVID mortality and the underlying reasons for mortality variances between hospitals across the country during the pandemic. They produced an interim report which showed that few trusts lie outside the expected range, indicating relative consistency in performance across English, Welsh and NI trusts. The following charts provided by CHKS show the Trust's central position relative to national peers in both the first and second COVID waves.

Figure 6: COVID First Wave (March to May 2020) ENHT mortality vs national

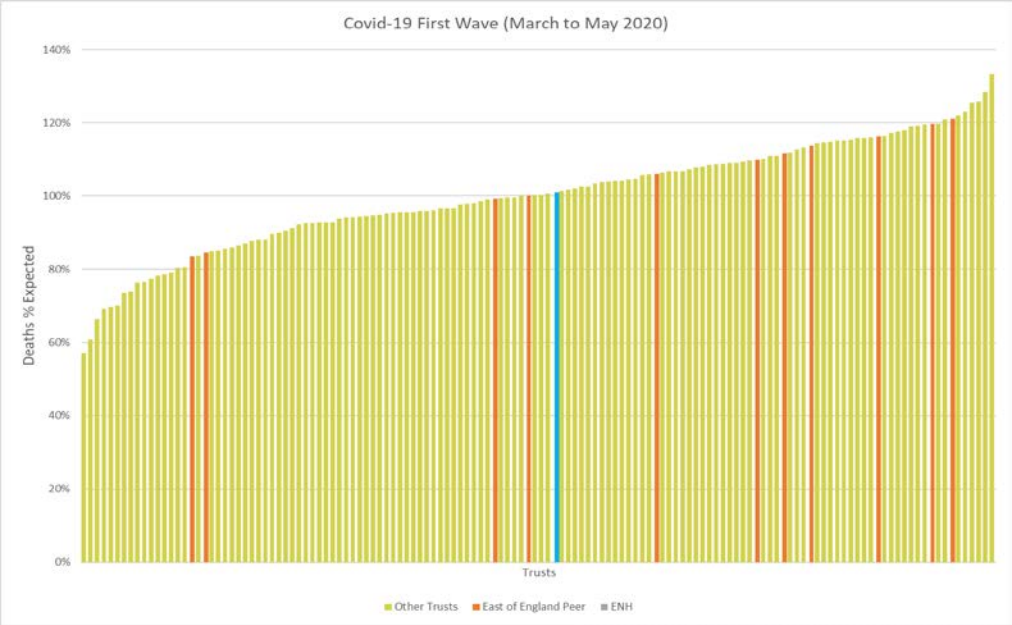
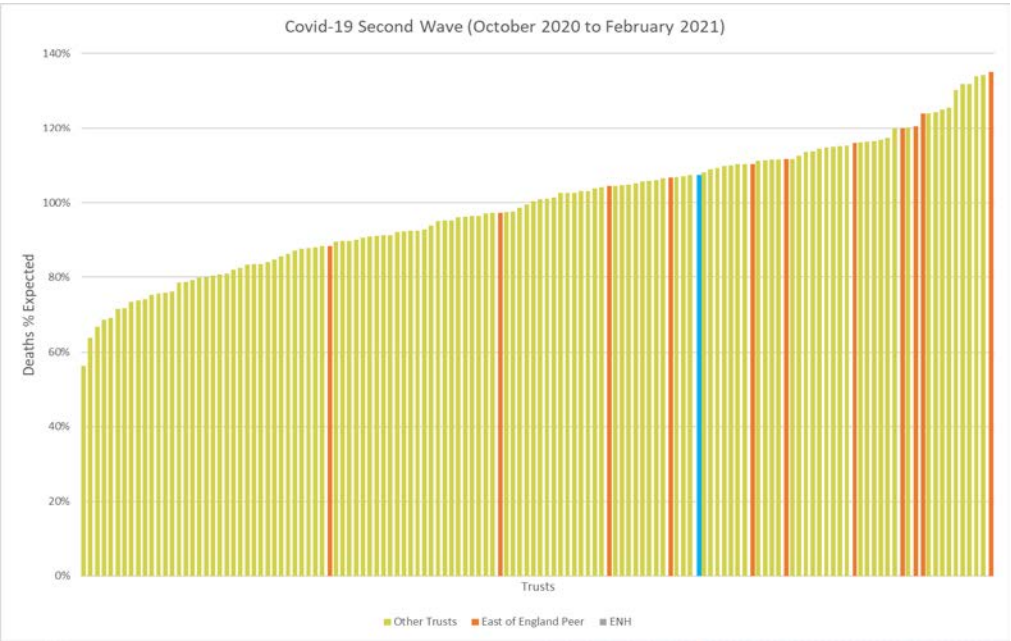


Figure 7: COVID Second Wave (October 2020 to February 2021) ENHT mortality vs national



The peer distributions above relate to the first wave (March to May 2020) and second wave (October 2020 to February 2021) using confirmed Covid in primary diagnosis and a risk-based methodology based on age and sex. This shows the Trust close to the national average for both waves, but with a higher figure for the second wave. It should also be noted that there was greater variation between Trusts in the second wave. The East of England peer group of Trusts are shown in red on the charts. For both waves, the Trust is below the average of these Trusts. It is noticeable that for the second wave, the East of England peer trusts have shown a general shift upwards.

2.1.2.2 Hospital acquired nosocomial infections

Work remains ongoing regarding hospital onset nosocomial infections. A standard operating procedure has been developed outlining the Trust's approach pursuant to NHS England and NHS Improvement (NHSEI) patient safety response to reporting, reviewing and investigating hospital-onset COVID-19 and COVID-19 deaths during a period (February – May 2021) of exceptional pressure on our health services.

All probable/definite hospital onset COVID nosocomial infections, where COVID appears on Part 1a/1b of the death certificate are subject to the outlined process. This involves the conduct of a mortality review with subsequent consideration by the SI Panel. To date 78 cases have been identified where it has been deemed likely that the patient contracted COVID in hospital and sadly went on to die. Mortality reviews have been completed, with details uploaded to Datix for ongoing handling by the Patient Safety team. To date 50 deaths have been declared as SIs, some individual and some as part of outbreak thematic SIs.

2.1.3 COVID-19 and mortality review

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 January 2021 all but urgent requests were again suspended. From March 2021 reviews recommenced. By the end of April 2021 when the review year closed, despite the significant challenges posed by the pandemic, 837 (54%) of deaths in scope had been reviewed.

As previously reported, in additional to our BAU service, in order to better understand the impact of COVID-19, reviews of two specific cohorts of patients were identified for further scrutiny:

i) Patients who died on a readmission to hospital within 30 days of discharge:

   Following a high-level review by the Head of Coding it was agreed that a clinical review of those who were readmitted within 5 days of discharge should be undertaken. Outputs are due in September.

ii) Patients who died in the community within 30 days of discharge:

   Again, following a high-level review by the Head of Coding a clinical review of those who died in the Community within 5 days of discharge was commissioned. This review is complete and outputs will be reported following once the report has been discussed by the Mortality Surveillance Committee in September.

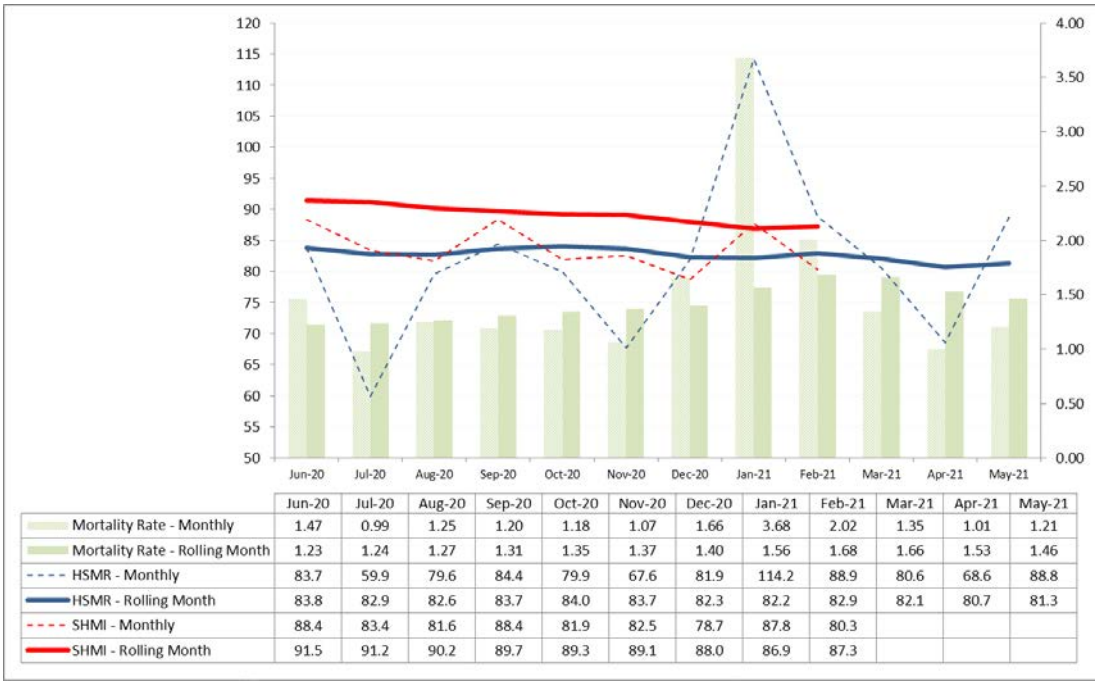
2.1.4 COVID Interim indications

- Mortality indicators have remained stable & largely unaffected – providing some indication that non-COVID death rates have not significantly increased
- CHKS 1st wave report indicates positive performance compared to peers
- CHKS 'interim' report shows the performance of the Trust is centrally placed nationally for both the first and second waves and compares favourably with the East of England average
- Significant increase in crude mortality Apr-20 and Jan-21
- Gradual reduction in % of over 71yr old deaths, but they still accounted for a large proportion of deaths in the second wave
- ICNARC Quality report 1 Apr-20 to 30 Sep-20 shows strong results for Critical Care risk-adjusted mortality rates
- Negative impact on #NOF mortality (see 2.4.2 below).

2.2 Key mortality metrics

2.2.1 Trust key metrics overview

Figure 8: Trust Key Mortality Metrics: Latest Position



	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Mortality Rate - Monthly	1.47	0.99	1.25	1.20	1.18	1.07	1.66	3.68	2.02	1.35	1.01	1.21
Mortality Rate - Rolling Month	1.23	1.24	1.27	1.31	1.35	1.37	1.40	1.56	1.68	1.66	1.53	1.46
HSMR - Monthly	83.7	59.9	79.6	84.4	79.9	67.6	81.9	114.2	88.9	80.6	68.6	88.8
HSMR - Rolling Month	83.8	82.9	82.6	83.7	84.0	83.7	82.3	82.2	82.9	82.1	80.7	81.3
SHMI - Monthly	88.4	83.4	81.6	88.4	81.9	82.5	78.7	87.8	80.3			
SHMI - Rolling Month	91.5	91.2	90.2	89.7	89.3	89.1	88.0	86.9	87.3			

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 as reported by CHKS. This shows that the rolling 12 month position continues to be stable for HSMR and SHMI.

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 1.52%, and is 1.56% for the Model Hospital Peers 2021 (MHP) for the twelve months to May 2021. This compares to 1.46% within ENHT for the same period. The Trust's locally recorded crude mortality rate, stands at 1.41% for the latest twelve months to July 2021.

HSMR: Our rolling 12 month HSMR has remained broadly stable, with only small fluctuations seen. 81.16 was reported for the latest period (June 2020 to May 2021), compared to 82.92 for the previous release March 2020 to February 2021.

SHMI: CHKS reports SHMI to February 2021 as 87.36, with the Trust continuing in the 'lower than expected' Band 3.

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 March 2020-February 2021 SHMI calculation, 4.2% of the Trust's spells were excluded (compared to 1.3% in the previous report).

NHS Digital notes there has been a fall in the number of spells for most trusts due to COVID-19 impacting on activity from March 2020 onwards and appears to be an accurate reflection of hospital activity rather than a case of missing data.

2.2.2 Trust In-month trend (crude/HSMR)

Figure 9 below provides the latest available in-month position, not only for crude and HSMR mortality rates, but also volume of deaths. The peak of the first wave of the COVID-19 outbreak is shown by the spike in number of deaths in April 2020. The second wave of the COVID-19 outbreak peaked in January 2021.

In the subsequent three months there has been a sharp decrease in the number of deaths and reduction in the Crude Mortality rate. However, this has been followed by a small increase in May 2021, mirrored by HSMR which suggests that this increase in the number of deaths might not be COVID-19 related.

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.

Figure 9: Trust Crude Mortality/HSMR latest in-month trend

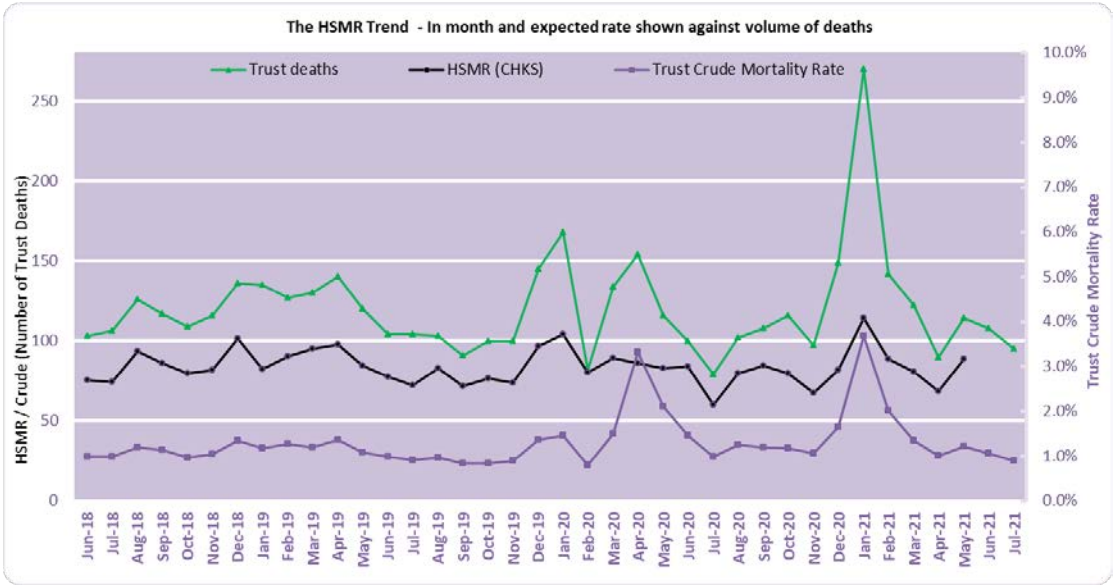
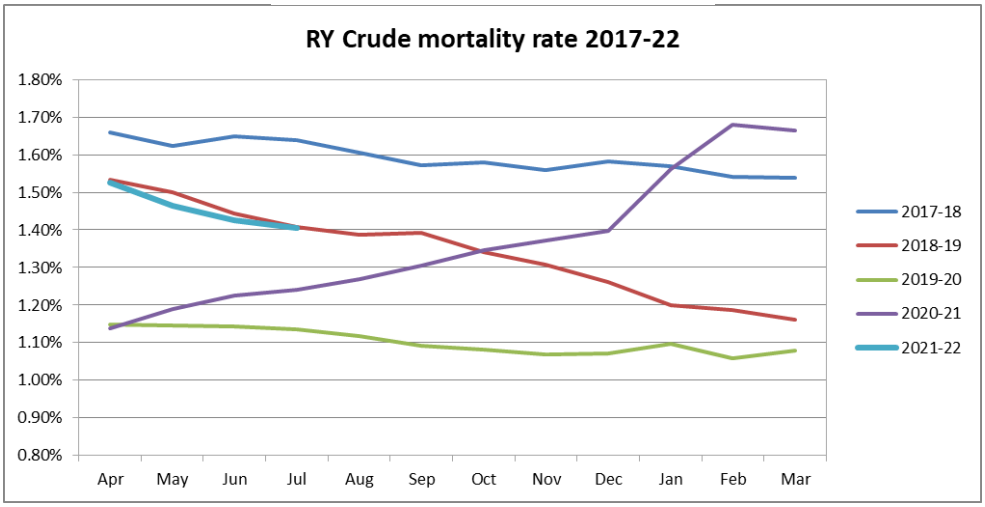


Figure 10 shows the trend in crude mortality rates over recent years. While this provides a good indication of the improving picture up to February 2020, it should be borne in mind that it has not been possible to use data solely from one source. This is due to the need for rolling year calculations to be based on changing data sources (our data warehouse [EDW] and most latterly CHKS).

Figure 10: 5 year crude mortality trends

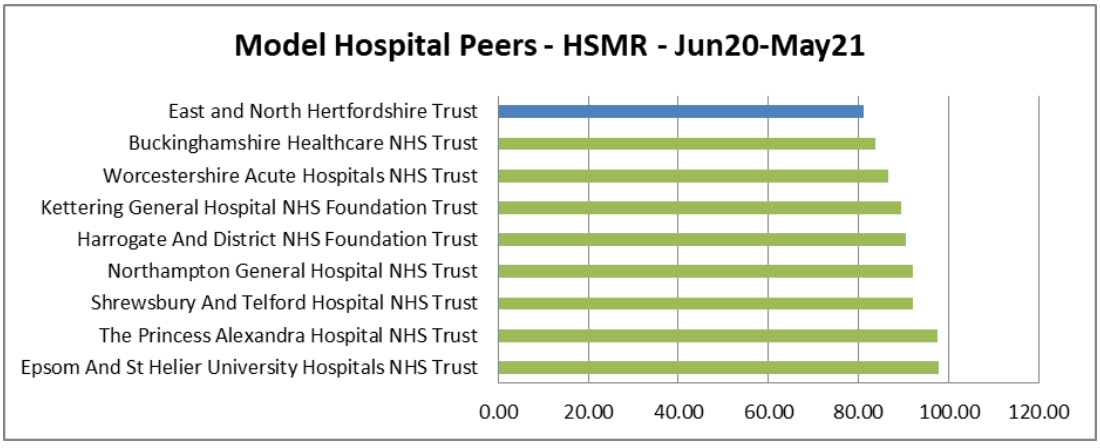


The downward direction of travel of the rolling year crude mortality rate reflects the lower number of deaths following the peak (January 2021) of the second wave of the COVID-19 outbreak.

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 significant COVID periods.

2.2.3 Trust HSMR peer comparison

Figure 11: Trust Model Hospital Peer comparison



For the purposes of performance assessment, 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, as it was felt that this would provide a better indication of performance. The constituents of this group have recently been updated. Figure 11 above shows how well placed we are within this group.

2.2.4 Divisional HSMR performance

Table 3: Monthly Trust and Divisional HSMR June 2020 to May 2021

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Rolling 12M
Unplanned Care (Spec)	78.9	90.2	62.1	87.8	88.8	84.1	74.2	85.8	121.5	105.6	83.9	77.2	98.7	87.6
Planned Care (Spec)	136.4	77.1	66.4	54.9	73.8	79.3	66.3	87.8	119.7	53.3	86.4	26.3	83.7	74.1
Cancer Pod (Spec)	22.8	0.0	15.6	0.0	23.8	26.6	0.0	15.0	15.6	0.0	26.4	41.3	0.0	13.2
Trust	**83.0**	**83.7**	**60.0**	**79.6**	**84.4**	**79.9**	**67.6**	**81.9**	**114.2**	**88.9**	**80.6**	**68.6**	**88.8**	**81.2**

Source: CHKS (scorecard alerts coloured; Specialty on Discharge)

Table 3 shows the Trust and Divisional monthly HSMR performance for the latest rolling 12 month period to May 2021. The CHKS red and amber alerts coding has been used to show HSMR above the 75th percentile Model Hospital Peer 2021 (MHP) group value, with red being statistically significant and amber not statistically significant. Please note this table is not comparable to the previous report as we are now using the updated Model Hospital Peer 2021 (MHP) group.

2.3 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. Using 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 2020 – February 2021).

The red alert is relative to peers in our Model Hospital Peer (2021) group.

Table 4: Key Quality Measures June 2020 – May 2021

	Trust Total		Elective		Non-Elective	
HSMR	81.2	↓	89.1	↑	81.1	↓
SMR	92.5	↓	115.3	↑	92.2	↓
Average Length of Stay	1.8	↓	0.2	↔	3.8	↔
Readmissions within 28 days (%)	8.9%	↑	4.2%	↑	**14.6%**	↑

Source: CHKS (scorecard alerts coloured)

At February 2021 Mortality Surveillance Committee the issue of readmissions was discussed. It was agreed it would be beneficial to work more closely with Primary Care, perhaps by way of a regular report to PCNs. Initial work by the Head of Coding commenced to move this forward. Discussions to date have highlighted the challenge of data sharing and GDPR considerations.

2.4 Mortality alerts

2.4.1 CQC CUSUM alerts

Following the closure of the Septicaemia alert, there have been no new CQC alerts in Q1.

The last report showed there had been a significant negative shift in sepsis HSMR performance since the rolling 12 months to November 2020.

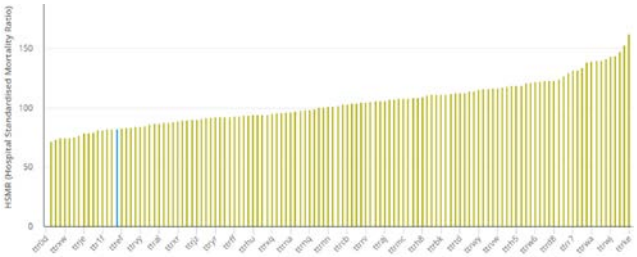
This appeared to be largely due to a significant spike in our in-month Sepsis HSMR in January and February 2021.

The Head of Coding undertook a review of the coded data for the two spikes in January and February 2021. It was found that there had been an element of confusion regarding the appropriate interpretation of detail contained in the corresponding death summaries. A review of Q1 2021-22 showed a similar theme, with issues immediately rectified. Unfortunately, it is too late to make changes to the lesser spike in July 2020.

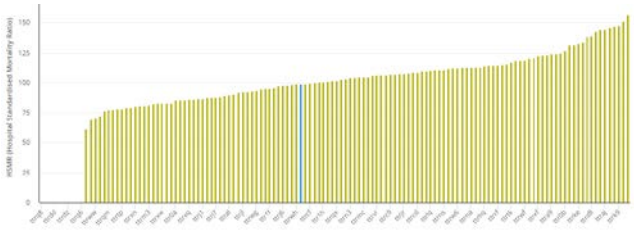
Amendments to Q4 errors should be reflected in the most recent CHKS refresh. While the chart below shows an improved position to the last report, it is still significantly worse than the position towards the end of 2020.

Figure 12: Latest vs November 2020 Sepsis R12M HSMR

Septicaemia (except in labour)
HSMR R12M to November 2020: national peer comparison

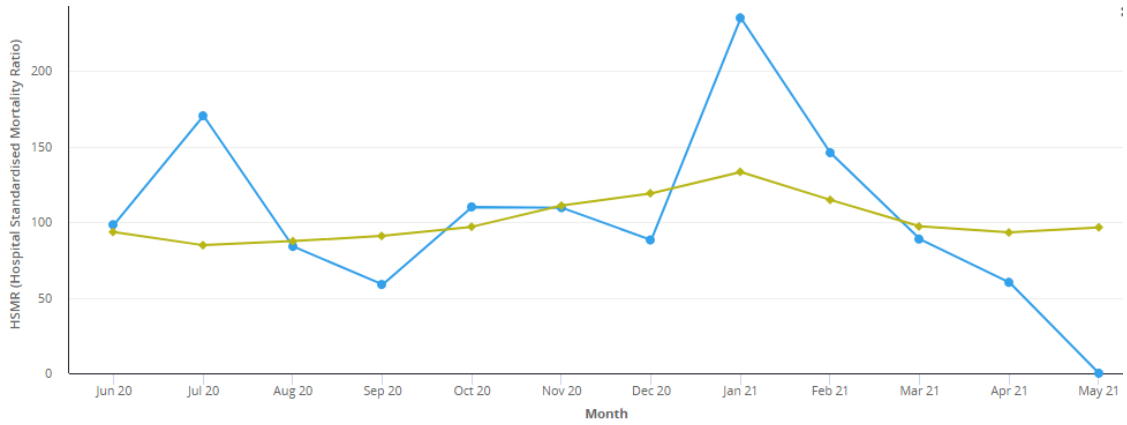


Septicaemia (except in labour)
HSMR R12M to May 2021: national peer comparison



Looking at the latest in-month Sepsis HSMR timeline, a significant peak remains in January 2021. For this reason, the Head of Coding has been asked to take a further look at the underlying data.

Figure 13: Septicaemia (except in labour) in-month HSMR Jun-20 to May-21



Throughout the pandemic the sepsis team continued to operate in difficult circumstances. The table below reflects the ongoing challenge regarding the achievement of sepsis targets:

Table 5: Sepsis: ED/Inpatients key data: Q1 2021-22

Metric	Target (per ¼)	Apr-21	May-21	Jun-21
Inpatient				
Sample Size	50	31	22	18
Antibiotics Within 1 Hour of Red Flag	90%	75%	72%	64%
Average Time to Receiving Antibiotics	60 mins	12 mins	36 mins	66 mins
Emergency				
Sample Size	50	42	41	51
Receiving Antibiotics Within 1 Hour of Red Flag	90%	71%	82%	80%
Average Time to Receiving Antibiotic	60 mins	82 mins	30 mins	40 mins
Sepsis 6 Bundle Compliance	90%	16%	34%	37%

Key updates from the Sepsis team include:

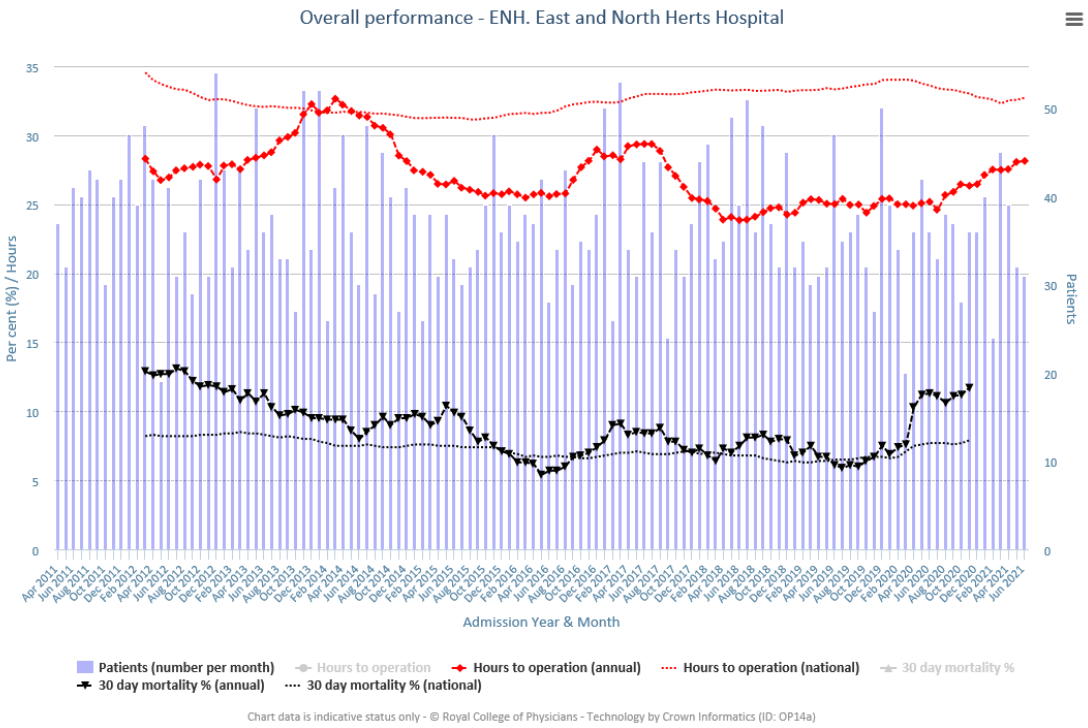
- Compliance has improved throughout the quarter as a result of reduced pressure from the pandemic and the effort of the team
- The team has gone through management changes and a new band 7 has been appointed
- Support to staff in the management of septic patients has continued with the provision of bed side teaching
- The team will shortly restart teaching sessions aimed at helping staff to gain confidence in the management of the septic patients
- Link nurses are being recruited to help with data collection and to share bedside teaching
- Ongoing collaboration with the AKI team and the nutrition nurse specialists to improve sepsis compliance
- Sepsis grab bags have been reinstated in every in-patient ward area to try to improve compliance. Discussions are being held with other areas (e.g. renal units and MVCC) to try to extend the scheme to these areas.
- Sepsis posters have gone up on all wards to remind people of the sepsis flags and what to do if they suspect sepsis.

2.4.2 Other external alerts

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

The below chart is the latest from the National Hip Fracture Database. While some data has been updated to June 2021, 30 day mortality is only showing to November 2020.

Figure 14: NHFD data to June 2021



Unfortunately this shows the Trust's 30 day mortality performance during the pandemic has suffered greatly, with mortality to the end of November 2020 significantly above the national average.

As previously reported, on 2 June 2021 we received notification from the NHFD that in the forthcoming annual report we would be showing as a 3 standard deviation outlier. Following discussion at June Mortality Surveillance Committee an initial response was provided outlining our intended course of action. Central to this was the formulation of a small working group to review the situation and report on its findings.

This report has been submitted to September Mortality Surveillance Committee for discussion and approval. Outputs will be provided in the next quarterly report. The report will also be shared with the CCG and CQC.

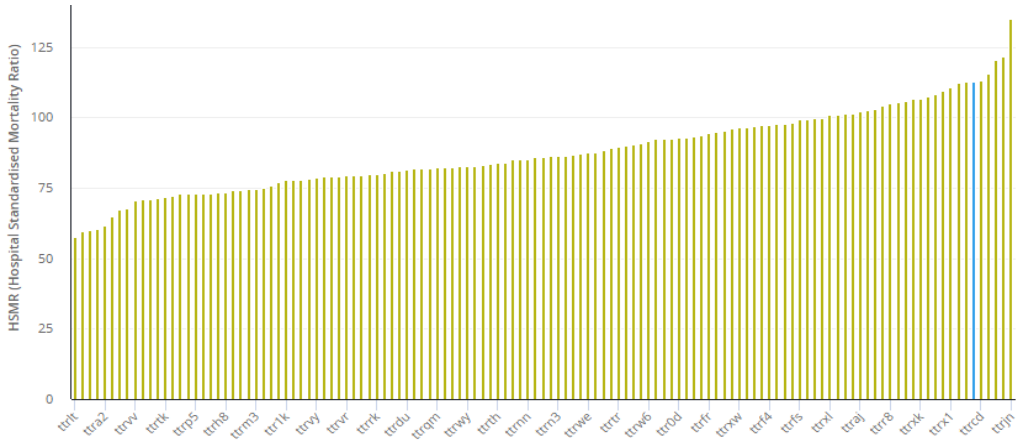
National Stroke Audit: Mortality Alert (January 2020)

- We were contacted by the Sentinel Stroke National Audit Programme (SSNAP) in January 2020 advising that while our position was not above the limit of 3 standard deviations from predicted mortality, and we were therefore not classified as a mortality outlier, we were 'quite close' to the threshold
- Collaborative work was instigated between Stroke and Coding aimed at creating a regular monitoring system, though limited progress was been made during the COVID pandemic
- In the meantime, while not an outlier, Stroke mortality has remained high relative to the national average and this continues to be monitored
- Our SSNAP rating has remained in category C. The service has attributed the lack of improvement to the continuing therapy issues, as well as challenges relating to COVID pressures and screening delays

- The stroke team is contributing to regional initiatives involving ISDN's with working groups set up to review all aspects of the wider stroke pathway
- Monitoring of Stroke data and mortality reviews continued with extra scrutiny given to target breaches.

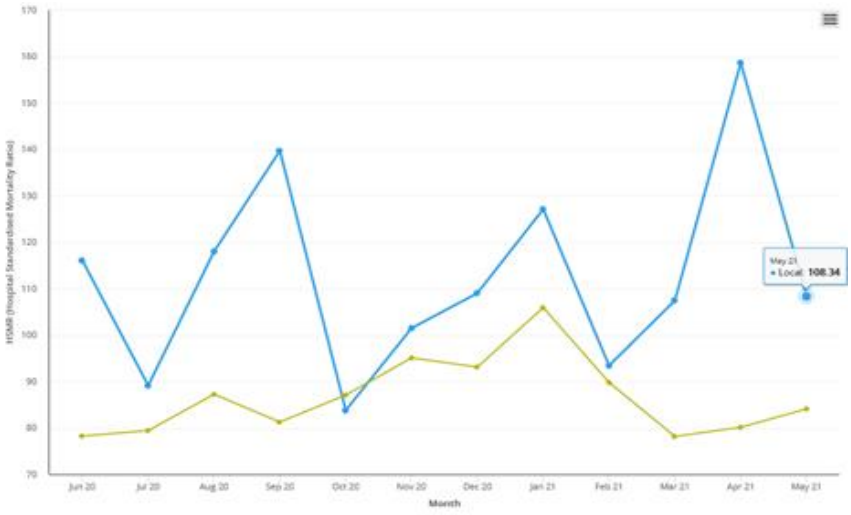
It has been noted that our position relative to the national picture has deteriorated since the June report, leaving us poorly placed in comparison to our peers. Latest HSMR stands at 112.57 for the rolling 12 months to May 2021.

Figure 15: Stroke HSMR R12M to May-21: National Comparison



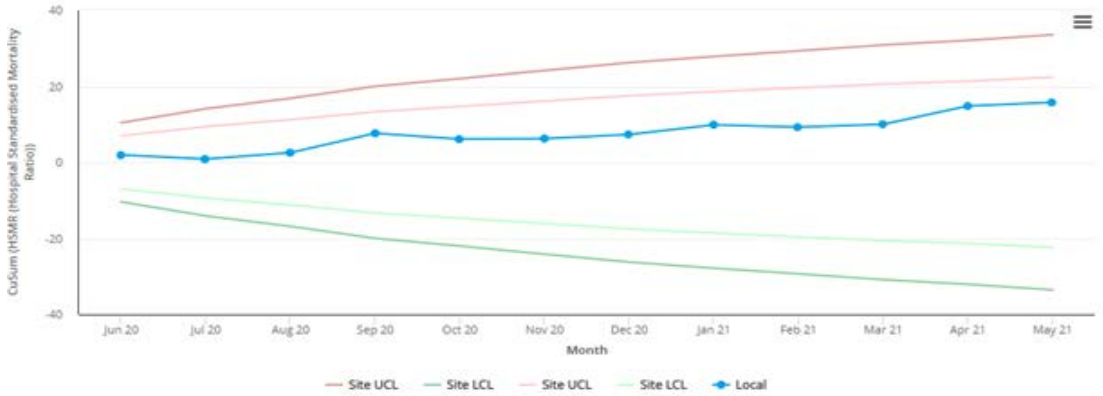
Looking at the in-month picture shown in figure 16 below, while there was a spike in HSMR in April 2021, this was not underpinned by a significant increase in deaths. At the same time we do appear to have been consistently running above the national average for the last 12 months.

Figure 16: Stroke in-month HSMR to May-21



At the same time it should be noted that, statistically, we are not an outlier, as the below chart clearly shows.

Figure 17: Acute Cerebrovascular Disease CUSUM chart June 2020 to May 2021



A coding review has been requested and dependent on the outcome, a clinical review may be instigated.

National Emergency Laparotomy Audit (NELA)

November 2020 saw the publication of the National Emergency Laparotomy Audit – Sixth Patient Report covering procedures carried out between December 2018 and November 2019. Data submitted for this audit has shown significant improvement for the Trust in multiple areas, with our adjusted mortality rate reducing from 13.0 to 10.3 in comparison to the previous year.

At the same time the impact of COVID has meant that the actions that the NELA team wanted to have in place following the AHSN February 2020 peer review, are only now being realised.

As the Trust continues to face the challenges presented by the COVID pandemic, every effort is being made to maintain the focus on important NELA improvement work. Notable steps forward include:

- The creation of a NELA area on Qlikview, enabling the availability of real time data, which has been a key achievement in support of ongoing improvement initiatives
- Expansion of the NELA team to include an ED consultant and geriatrician
- A crucial development has been the adoption of an MDT approach to high risk patients which includes surgeons, anaesthetists, intensivists and in future a geriatrician (as the majority of deaths occur in the elderly/frail group of patients).

The improvement measures above mean the service is now in a much better position to monitor monthly outcomes and it is anticipated that mortality for year 7 will be between 8-10% bringing us closer to aligning with the national average.

2.4.3 HSMR CUSUM alerts

The latest release from CHKS showed two HSMR CUSUM amber alerts for the rolling year to May 2021 (Amber alert: 95% detection threshold). Table 6 details HSMR for the alerting CCS groups, sorted in descending order by “Excess Deaths”.

Table 6: HSMR CUSUM Alerts June 2020 to May 2021

	Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths
133 - Other lower respiratory disease	155.50	15	9.7	5.4
150 - Liver disease; alcohol-related	111.44	27	24.2	2.8

Source: CHKS (CUSUM alerts coloured)

Figure 18 below shows the Trust HSMR CUSUM for Other lower respiratory disease with an amber alert for the 12 month period to May 2021 (it breached the two standard deviations upper control limit between November 2020 and January 2021).

When this condition first alerted a review was undertaken by the Head of Coding. This indicated there were no errors in coding and did not give rise to clinical concerns. As it has remained in the region of the 2 standard deviation mark, it will continue to be monitored

Figure 18: Other lower respiratory disease CUSUM chart June 2020 to May 2021

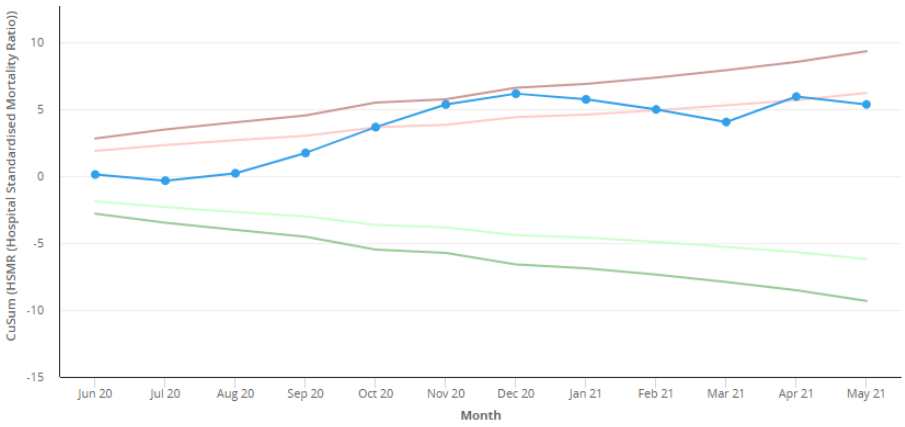
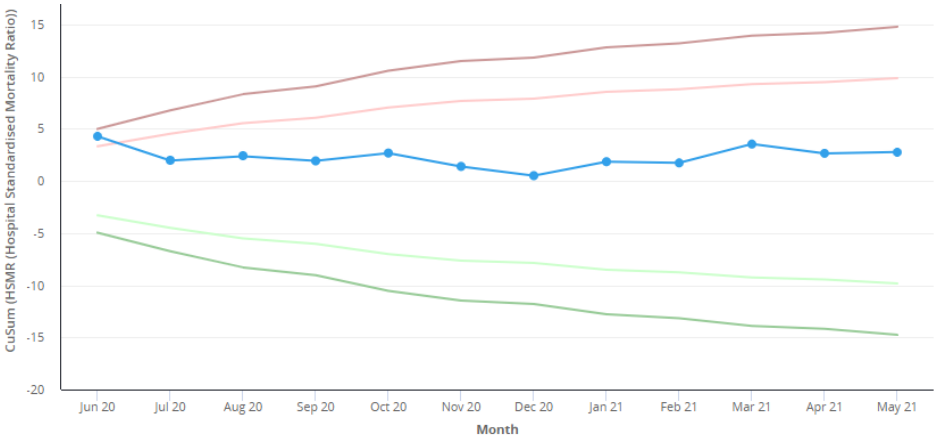


Figure 19 below shows the Trust HSMR CUSUM for Liver disease; alcohol-related for the last 12 months to May 2021 and that it has breached the two standard deviations upper control limit (pink line) in the first month of this period. After which it has stabilised below the second standard deviation level.

Figure 19: Liver disease; alcohol-relate CUSUM chart June 2020 to May 2021



Following recurrent alerts the Cardiology Clinical Director presented the outputs of the service review at June Mortality Surveillance Committee. This focussed on Acute

Myocardial Infarction as this appeared to be the key area of ongoing concern. Key findings were:

- There were high numbers of 'out of hospital' cardiac arrest where:
    - The patient never had a return of spontaneous circulation
    - The patient died of severe acidosis complicating prolonged 'down time'
    - The patient died of hypoxic brain injury
    - Query - does ENHT have more OOHCA as a proportion than other PPCI centres?
    - Significant numbers treated 'palliatively' (appropriately so) but should be similar in other PPCI centres
- Significant numbers where there was no evidence of acute MI on admission or a cause of death.

It was agreed that Cardiology and Coding should liaise to jointly review of all cases with an admitting diagnosis or cause of death of acute MI to identify and exclude 'coding error' cases and ensure appropriate learning. It was also agreed that a re-Audit should take place in six months to assess the effectiveness of the quality improvement initiative and identify any ongoing monitoring/improvement requirements.

2.4.4 SHMI outlier alerts

From the latest CHKS report there were no Red outlier alerts for SHMI groups in the period March 2020 to February 2021. (Amber alert: lower confidence limit above national average; Red alert: lower confidence limit in upper quartile).

2.5 Specific actions to address high mortality conditions

The HSMR/SHMI trends of alerting groups are tracked and monitored via the Mortality Surveillance Committee. Investigation usually starts with a coding review. 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.

2.6 Associated trust initiatives

2.6.1 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 been indicated that all Trusts should be compliant with the 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.

The 2019/20 results from the audit and assessment of compliance against the four prioritised standards were:

- Standard 2: Time to Consultant Review – not met
- Standard 5: Access to Diagnostics - met
- Standard 6: Access to Consultant-directed Interventions - met
- Standard 8: On-going Review – not met

Following the development and submission of speciality level business cases last year, a clinical Seven Day Service Investment Review Panel was held at the beginning of March 2020 to prioritise the investment recommendations for the delivery of seven day services in 2020/21. Further progress was postponed due to the needs of the COVID-19 pandemic. Our internal auditors recently completed an audit, but the outcomes have not yet been signed off. However, there were a number of service changes as a response to the pandemic which temporarily provided additional capacity to meet standards 2 and 8 such as 24/7 general medicine consultant rota. There have been other improvements such as 7 day consultant ward rounds in general surgery, urology and orthopaedics.

The plan for 2021-2023 is to commence the roll-out of a new job planning policy and process. Part of this includes meeting with specialty leads to discuss and agree expectations and plan for the year ahead. It is intended that these discussions will include planning for a full 7 day service provision, in order to understand the financial implications of the resource levels required. Due to a number of obstacles, the job planning roll out has not yet commenced.

A major step towards improving 7 day service provision in unplanned care, is a staff consultation which is to be undertaken this summer for all those consultants on the acute medicine and general internal medicine rota. The aim is to improve continuity of consultant led post take for patients admitted overnight and for morning handover. Outputs will be reported in due course.

2.6.2 Care bundles

Following the establishment of the Medical Director Office, discussions have taken place regarding how best to provide Director level clinical support to drive this work forward. To date it has been agreed that this work will be led by the Associate Medical Director for Clinical Risk, Audit and Compliance, who has commenced research into approaches taken by trusts in our region. As we begin to emerge from the latest COVID peak, the plan for 2021-22, Q1 and Q2 is to focus on cardiology pathways including acute coronary syndrome (ACS), heart failure and primary percutaneous coronary intervention (PPCI).

In the meantime there are already quality improvements underway regarding key care bundles such as Sepsis, AKI and Pneumonia. Sepsis and AKI work has continued during the COVID period, albeit in a different shape.

2.6.3 Medical Examiner

The Medical Examiner function is a process which sits outside the normal structure of the Trust and is responsible to the Medical director and the Regional Lead Medical Examiner structure. At present during the initial phase of introduction the process is non-statutory but following the Health and Care Act 2021 will become statutory in April 2022.

The Medical examiner process has now been fully rolled out and all deaths occurring within the Trust are scrutinised by the Medical Examiners. The Medical Examiner Office is now fully established with adequate office space.

The next phase of the roll out will be to all deaths including those in the community. The Lead Medical Examiner and staff are working towards this and will be liaising with our community colleagues. This expansion will require a significant increase in the number of MEOs and Medical Examiner sessions.

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 has commenced from the outset of the service with priority mortality reviews requested where any concerns have been raised.

Development work regarding the migration of the Trust's mortality review process to the Datix iCloud platform also involves consideration of the potential for incorporation of the Medical Examiner process to further streamline our governance, quality and learning framework. However, a national online reporting system (to collate data and concerns raised) is due to accompany the full national roll out of the Medical Examiner Service from 2022. This raises questions regarding the feasibility and efficacy of integration with Datix.

2.6.4 Coding/data quality

The heads of both Coding and Data Quality continue to drive forward quality improvement initiatives. The Data Quality team has created an on-line training package covering awareness of Data Dictionary and national standards around RTT. Clinical coding is reaching out to clinicians to help improve clinical documentation and is in the process of setting up regular audits and meetings on a rotational basis. Awareness sessions with junior doctors have been set up, in which the importance of documentation is discussed and presented. Unfortunately, attendance to date has been disappointing.

Regular coding training sessions are used as a forum to provide feedback on the various reviews undertaken by the Clinical Coding department. These reviews range from acuity of inpatient data to mortality reviews. Clinical Coding continues to manage the Independent sector activity recording on Lorenzo with one dedicated staff member.

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, development work to support implementation is continuing. Following concerns raised by the Mortality Surveillance Committee, it had been agreed that the mortality module would not go live until the link between the Datix system and Lorenzo had been established. Subsequently due to the degree of uncertainty as to if and when this would be possible a decision has been made to radically change the form of the mortality review. It is now proposed to base the content on the nationally developed SJR format. While the link to Lorenzo remains preferable, adoption of the SJR format is not dependent on it.

This change of plan does mean there is still significant development to be done. The potential for adopting a format already developed by another trust is currently being investigated.

Current progress towards implementation has also been hampered by further technical IT issues.

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 Q1 2021-22.

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 2021-22 deaths which can appear to skew the data. Therefore for the sake of transparency and robust governance this report details ACONs relating to all deaths which have been concluded during the quarter in question where the Mortality Surveillance Committee agreed an avoidability of death score of 3 or less (irrespective of the year in which the death occurred). It should be noted that in Q1 no ACONs were given a score of 3 or less.

Table 7: Q1 2021-22 Concluded ACONs: Avoidability Score ≤3

ID	Year of death	Serious Incident	Avoidability score	Avoidability definition
-	-	-	1	Definitely avoidable
-	-	-	2	Strong evidence of avoidability
-	-	-	3	Probably avoidable: more than 50-50

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: Concluded ACONs: Quality of Care Rating Scale

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 2021-22 Concluded ACONs: Quality of Care Rating D/E

Quality of Care Rating	ID	Serious Incident
D	433	No
	447	No
	480	No
	456	No
	460	No
	487	No
	490	No
	516	No
E	492	No
	545	No

From the above table it can be seen that there were 10 cases where care was considered to have been poor or very poor. None of these cases had been declared as Serious Incidents.

Three cases related to end of life care, two involved lack of specialist review, two cases involved the lack of recognition of patients condition, one related to a missed #NOF, one case related to concerns regarding a delay in the insertion of a NGT and one case involved the management of a perforated bowel.

Table 10 below provides a year to date summary of concluded ACONs indicating both avoidability of death and quality of care ratings.

Table 10: 2021-22 concluded ACONs ratings

Apr-Jun 2021-22: Concluded ACONs discussed by Mortality Surveillance Committee		
Avoidability of Death Rating	**Definition**	**SI/RCA detail**
1	**Definitely avoidable**	**-**
2	**Strong evidence of avoidability**	**-**
3	**Probably avoidable, more than 50-50**	**-**
4	Possibly avoidable, but not very likely, less than 50-50	3
5	Slight evidence of avoidablity	4
6	Definitely not avoidable	9
Quality of Care Rating	**Definition**	**SI/RCA detail**
A	Excellent	1
B	Good	1
C	Adequate	4
D	**Poor**	**8**
E	Very poor	2

Note: the above data relates to ACONs concluded during 2021-22, irrespective of when the death occurred.

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 11: Q1 Learning Disability Deaths

	Apr-21	May-21	Jun-21
Learning disability deaths	1	1	3

In Q1 five deaths occurred of a patient with a learning disability. These have been reported to the national LeDeR programme. So far one internal review has been completed which did not raise concerns regarding our care. Copies of all our reviews will be provided to support the local external LeDeR mortality review.

In March 2021 NHS England and NHS Improvement published an updated LeDeR Policy which outlined a number of changes to the existing process. While many of the changes will be the responsibility of the ICSs, an important development affecting the Trust is the inclusion, from 2021, of patients who have a diagnosis of autism. Discussions are currently taking place with our Safeguarding Leads to ensure our internal policies and processes are appropriately updated to reflect the new requirements.

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.

Prior to COVID, Internal approval was given to include a supporting alert on Lorenzo. It was noted that further work would be required prior to the alert being activated, including creation of a supporting SOP to ensure clarity regarding identification of relevant patients and use of the alert. This was to be taken forward via the ‘Treat as One’ Task and Finish Group. The appropriateness of such a flagging system is being revisited by the Mental Health Strategy Working Group.

Importantly, now that clarity has been gained as to which diagnoses should be considered for this cohort of patients, a regular report of deceased patients is run by the Business Information team. This uses the relevant ICD10 codes recommended by HPFT.

Four deaths of a patient with a mental illness were identified in Q1.

Table 12: Q1 Severe Mental Illness Deaths

	Apr-21	May-21	Jun-21
Severe mental illness deaths	2	0	2

Mortality reviews of two of these deaths have so far been completed. One was a MVCC death which was felt to be unavoidable, but with some local learning. The other case has been declared an SI and is currently under investigation.

3.2.4 Stillbirth, children and maternity deaths

Q1 statistics are provided below:

Table 13: Q1 Stillbirth, Children and Maternity Deaths

	Apr-21	May-21	Jun-21
Stillbirth	3	1	1
Children	0	0	1
Maternity	0	0	0

There were no serious issues raised regarding the stillbirths, but a number of points of local learning were identified.

The child death related to a child with learning disabilities. Following discussion by the SI Panel a number of points of local learning were identified and an action plan is in progress.

3.2.5 Serious Incidents involving deaths

Table 14: Q1 Serious Incidents Involving a Patient Death

Serious Incidents involving the death of a patient	Apr-21	May-21	Jun-21
Serious Incidents reported	3	5	15
Serious Incidents: final report approved*	0	0	0
Key learning: N/A since no SI reports were approved in the quarter			

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

3.2.6 Learning from complaints

Table 15 below provides detail of the number of complaints received in Q1 that relate to a patient who has died while an inpatient.

Table 15: Q1 Complaints Involving an in-patient Death

	Apr-21	May-21	Jun-21
Complaints received relating to an in-hospital death	0	1	0

Learning: vital importance of:

- Robust handover
- Clear communication with family regarding patient's care
- Correct/clear documentation and instruction on drug chart.

3.2.7 Learning from inquests

Table 16: Q1 Inquests into a Patient Death

	Apr-21	May-21	Jun-21
Requests for a Report to the Coroner	4	3	8
Regulation 28: Report to Prevent Future Deaths	0	0	0

3.2.8 Learning from mortality reviews

Prior to COVID cases raised as Areas of Concern (ACONs) as a consequence of mortality case record reviews, were central to the topics covered at clinical governance Rolling Half Days. The RHD meetings provided a forum for discussion, learning and the creation of appropriate Specialty-specific action plans and represented a key element of the Trust's learning from deaths framework.

Changes necessitated by COVID-19 meant that fewer ACONs were concluded during the pandemic, partly due to competing commitments and partly due to changes to the conduct of Specialty meetings. Now in the recovery phase we are working hard to clear outstanding cases.

As detailed above in 2.1.2.2, the Trust has committed to reviewing all probable/definite hospital onset COVID nosocomial infection deaths where COVID appeared on part 1a/1b of the death certificate. These deaths have now been reviewed with outputs provided to the Serious Incident Panel for consideration. Approximately half have been discussed and the majority declared SIs.

Throughout the year emerging themes are collated and shared across the Trust via governance and performance sessions and specialist working groups. The information will also be used to inform broad quality improvement initiatives.

Key themes from ACONs concluded in Q1 and Q2 will be amalgamated and included in the next Learning from Deaths report.

4.0 Options/recommendations

The Committee is invited to note the contents of this Report.

Appendix 1: ENHT Learning from deaths dashboard June 2021

East and North Hertfordshire NHS Trust: Learning from Deaths Dashboard: June 2021

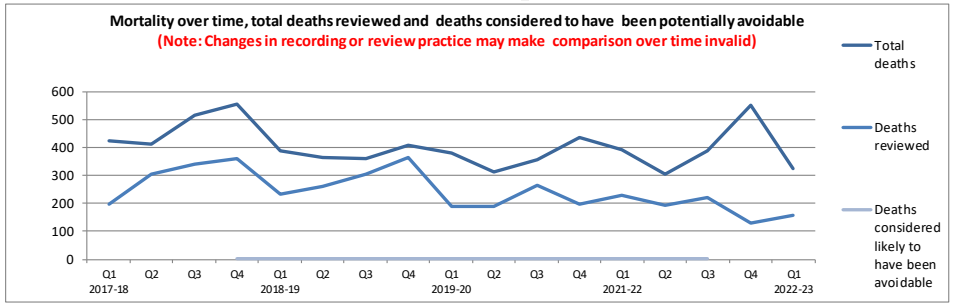
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by East and North Hertfordshire NHS Trust and is based on the dashboard suggested by the National Quality Board in its Learning from Deaths Guidance published in March 2017. Its purpose is to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Summary of total number of deaths and total number of cases reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
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
323	1634	157	769	0	2

Time Series: Start date 2017-18 Q1 End date 2021-22 Q1



Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	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%	This Year (YTD)	3	1.8%	This Year (YTD)	4	2.3%	This Year (YTD)	164	95.9%

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
5	22	5	23	0	0

Time Series: Start date 2017-18 Q1 End date 2021-22 Q1