Extraordinary Public Trust Board

Online meeting

30/06/2025 14:00 - 14:30

Agenda Topic	Presenter	Time	Page
Assurance rating guide			
STANDING ITEMS			
1. Declarations of interest For noting	Trust Chair	14:00-14:05	
2. Apologies for Absence For noting	Trust Chair		
3. HCP Committee For approval	Head of Corporate Governance	14:05-14:20	2
4. Quality Account For approval	Deputy Chief Nurse	14:20-14:30	126
5. Any Other Business For noting	Trust Chair		

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	3	
Report title	HCP advisory Committee and updated Standing Orders		**Meeting Date**	30 June 2025	
Author	Stuart Dalton, Head of Corporate Governance				
Responsible Director	Martin Armstrong, Deputy Chief Executive				
Purpose	**Assurance**	☐	**Approval/Decision**	☒	
	Discussion	☐	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers)*	**Substantial assurance**	☐	**Reasonable assurance**	☐	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

N/A

Summary of key issues:

This paper seeks approval for:

1) the creation of an East and North Hertfordshire (ENH) Health and Care Partnership (HCP) advisory, non-decision-making committee of the Board and approval of the committee's terms of reference;
2) revised Standing Orders covering both the creation of HCP Committee and the annual review of Standing Orders.

HCP Committee

The Hertfordshire and West Essex (HWE) Integrated Care Board (ICB) wrote to the Trust expecting it to move to shadow arrangements for hosting the east and north Hertfordshire HCP by 1 July 2025. At 4 June Board Seminar, Board members supported moving to a shadow host provider role for East and North Hertfordshire HCP place by 1 July as a first symbolic step towards a full host provider model. The Trust will work with partners between now and November to confirm our shared ambition and principles, and agree how we will work together as a partnership in that new model. Further work will be needed to agree a revised MOU between partners and a delegation agreement with the ICB, reflecting those principles and covering important areas including: risk share; dispute resolution; resourcing; data sharing etc. The Trust Board will need to approve the Delegation Agreement. The ICB has confirmed that this two phase approach is acceptable.

Two substantive changes have been made to the enclosed Standing Orders and Scheme of Delegation (SoRD) for creating the HCP Committee (comments have been added to differentiate HCP changes from the annual review changes):

- Page 29: Creation of the HCP Committee, which sets out the purpose.
- Page 50: Amending the Scheme of Reservation and setting out the Board reservations and delegations in relation to ICB delegations and the HCP Committee.

The proposed terms of reference for the committee are also presented for approval and largely mirror the existing ICB's HCP Committee terms of reference. Key differences are they do not confer any decision-making powers to the Trust's committee; it is proposed that there is a Non-Executive Director from both our Trust and Hertfordshire Community NHS Trust's Boards on the committee. It is intended that this ENHT shadow committee will meet in common with the ICB's HCP Committee during the transition period, and this close alignment in the terms of reference supports an 'in common' meeting arrangement.

Annual review of the Standing Orders, SoRD and Standing Financial Instructions (SFIs)

The other tracked changes reflect the changes the 14 January Audit Committee reviewed and supported as part of the annual review of Standing Orders.

Appendix 1: A paper setting out the HCP context, timeframes and a diagram of the proposed governance structure
Appendix 2: HCP Committee terms of reference
Appendix 3: Summary of annual review changes to the Standing Orders
Appendix 4: Standing Orders, SoRD and SFIs with tracked changes

Impact: *tick box if there is any significant impact (positive or negative):*

Patient care quality	☒	**Equity for patients**	☒	**Equity for staff**	☐	**Finance/ Resourc -ing**	☒	**System/ Partners**	☒	**Legal/ Regul- atory**	☒	**Green/ Sustai- nability**	☐

The biggest impact to flag is this is the first step in the Trust moving to becoming the host provider for the ENH HCP and place under a delegation agreement with the ICB. In this model, the Trust will be delegated responsibilities from the ICB on behalf of the HCP.

The goal of the Trust taking on a host provider role for the ENH HCP is to develop system place arrangements to improve services and outcomes for the east and north Hertfordshire population and tackle the wicked cross-organisational challenges that require cross-system partner solutions. In the context of national ICB savings requirements and HWE ICB merging with other ICBs, the host provider model enables local leadership and decision-making by local organisations who understand the place population needs and service challenges.

There are opportunities through this model of collective local decision-making to increase clinical and care professional leadership, to improve integration of care services and pathways, and to coordinate delivery and transformation across partners. It is important that the Trust develop the host provider model with partners to ensure we can exploit those opportunities. The Trust is working with the HCP Development Team, HCT and other partners to undertake a programme that allows us to agree collectively what the delegation should like, and importantly the operating model behind the delegation. This will consider the organisational development and relationships required to make the partnership successful in the future.

Whilst the proposed advisory committee does not change any legal duties at this stage, it is essential to understand that when the Trust moves from a shadow, advisory role to actual host provider then a range of legal duties transfer from the ICB to the Trust as well as potential financial liability. This is why it is intended to agree a risk share agreement to mitigate this financial liability. The Board will need to approve any delegation agreement.

Trust strategic objectives: *tick which, if any, strategic objective(s) the report relates to:*

Quality Standards	☒	**Thriving People**	☒	**Seamless services**	☒	**Continuous Improvement**	☒

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

BAF 7: System working. It is envisaged that the HCP will be the key engine for driving system improvements at East and North Hertfordshire place. Therefore it is hoped that ENHT taking on the host provider role for the HCP as requested by the ICB will start to mitigate this risk.

Report previously considered at & date(s):

4 June 2025 Board Seminar.
26 June Audit and Risk Committee reviewed and endorsed the proposed changes to the Standing Orders to create the HCP Committee.
The proposed way forward was discussed and supported at the June ENH HCP Board.
14 January Audit and Risk Committee reviewed and supported the proposed annual review changes to the Standing Orders.

Recommendation	The Board is asked to **APPROVE**: • the creation of an HCP Committee of the Board, with only advisory and no decision-making powers at this stage; • changes to the Standing Orders, SoRD and SFIs to reflect the creation of the HCP Committee and annual review changes; and • the Terms of Reference for the HCP Committee.

To be trusted to provide consistently outstanding care and exemplary service

APPENDIX 1: Context

East and North Hertfordshire Teaching NHS Trust

Letter from HWE ICB to ENHT and HCT Chief Executives as joint SROs for the east and north Hertfordshire Health and Care Partnership:
"The ICB asks that the HCP complete the necessary work to ensure that East and North Hertfordshire NHS Trust becomes host provider for the HCP from the 1st July 2025"

HWE ICB System Operating Model

Working with the system CEO group, HWE ICB has set out a new system operating model, in which the ICB will increasingly focus on its role as strategic commissioner and system convenor. Health and Care Partnerships (HCPs) will be the key vehicles for delivery, and will be delegated responsibility and budget from the ICB.

NHS providers and other local partners are expected to take a more prominent role through the HCPs in coordinating the services and health of their population.

The enH HCP had opted to remain a committee of the ICB Board, while the HCPs in south west Hertfordshire and west Essex had opted for a host provider model.

The ICB has now confirmed that its preferred model for HCP delegation is the host provider model.

The HWE system operating model is consistent with existing national policy[1,2,3].

The 10 Year Health Plan is expected to build on this with proposals to further develop place-based partnership and neighbourhood healthcare.

1. https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf
2. https://www.england.nhs.uk/long-read/working-together-in-2025-26-to-lay-the-foundations-for-reform/
3. https://www.hertsandwestessex.ics.nhs.uk/wp-content/uploads/2025/05/Model-ICB-Blueprint_-020525.pdf

HWE ICB Expectations of host provider

The ICB Chief of Staff has clarified the ICB's ask in two parts is as follows:

1. ENHT becomes convenor of the Health and Care Partnership

- As convenor, ENHT hosts HCP governance – there should be demonstrable progress by 1 July in bringing the enH HCP Board into ENHT governance, at least in shadow form.
- ENHT CEO is established as the sole SRO for the HCP.

2. ENHT is delegated specific ICB functions and budgets on behalf of the enH HCP

- By 1 July, ENHT and enH HCP partners should describe what will be different under the host provider model and set out a plan with clear timelines to develop the host provider model
- Implement that plan ensuring the involvement and engagement of HCP partners, in line with the timeline we set out – we have proposed to complete this work by end November
- Develop and agree a Delegation Agreement between HWE ICB and ENHT and make changes to ENHT governance in line with that Agreement
- Relevant ICB budgets are expected to be delegated from April 2026

Opportunities from delegation

NHS
East and North Hertfordshire Teaching NHS Trust

Delegation will better enable the Health and Care Partnership to improve services and health outcomes for the population of east and north Hertfordshire.

It aligns to ENHT's strategic theme of Seamless Services delivered through collaboration and coordination with partners.

Preservation of Local Identity & Voice
Host model enables local partners to collaborate at a local level to shape services and protects local influence in light of ICB clustering

Decentralised Decision Making
Faster, shared decision-making closer to the population that are impacted, with opportunity to tailor to specific population need and all local partners having influence.

Improved Integration and Coordination
Collective decision-making and alignment around shared outcomes and care continuity, reducing fragmentation

Greater Equity in Partnership Working
Ensures wider partners (incl. primary care) and VCFSE have a voice, and all partners contribute to shared delivery.

Opportunities for Service Redesign
Strategic alignment and joint innovation in care pathways and integration, reducing duplication and improving outcomes

Clarity, Stability and Risk Management
Defined roles, governance, and risk-share increase assurance across the system.

Stronger Partnership Voice with ICB
Host represents the partnership to the ICB, strengthening local lobbying and funding leverage.

Better use of resources
Greater ability to make best use of shared resources, and unlock economies of scale, allowing for reinvestment.

Key Programme Foundations

NHS
East and North Hertfordshire Teaching
NHS Trust

On 1st July, we take a symbolic but carefully measured step by establishing the Advisory Committee. This marks the beginning of our journey towards a more integrated partnership model. This initial move involves **minimal changes** to our existing infrastructure, ensuring stability while allowing time and space to **co-develop** the final model with our partners.

By the end of November 2025, our aim is to agree a **shared ambition** and build a **jointly agreed operating model** that enables effective delegation based on the opportunity of empowering local partners to work together to make the best decisions for communities and patients. **Clinically led transformation and delivery need to be central to the new model**.

How we move forwards to November 2025 (guided by a multi-organisational programme team)

Collaborative by Design
The delegation and partnership priorities have to be shaped *with* our stakeholders (HCT, ICB, Primary Care, HUC, the Local Authorities, and the VCFSE sector) through open, ongoing engagement. The future HCP model needs to reflect shared values, mutual priorities, and practical insight from across the system.

Co-creating Strategic Intent
The first phase of the work programme, running through July 2025, focuses on developing the strategic narrative of the partnership, building on the existing HCP strategy and three-year plan, and defining our collective ambition. This will be co-designed with partners to ensure the foundation of our collaboration is jointly owned and authentically grounded in our collective vision. It will serve as the compass for the remainder of the delegation programme.

Building the Operating Model
Between now and 30th November, our pivotal focus will be on developing the operating model - defining the relationships, culture, ways of working, and shared programme of activity. This will include establishing strong mechanisms for clinical and care professional engagement, ensuring the voices of those closest to service delivery shape how the HCP works.

Inclusive Leadership and Collaborative Culture
Designing the delegation model requires a review of current structures to ensure that the right people are involved in the right forums, and to help lead the partnership. A particular focus needs to be on clinical and care professional voices. Building trust and collaborative relationships is key, and we will explore an organisational development approach to support the culture and behaviours needed for effective joint working.

Strengthening Internal Delivery Structures
Exploration of internal delivery structure options to ensure that, as a Trust, we are equipped with the right capabilities and a clear system leadership approach - one that enables us to support, influence and contribute meaningfully to the evolving partnership.

System alignment
Our place-based programme reflects learning from the host provider models in the South West Herts and West Essex HCPs. We continue to work closely with the other HCPs and with HWE ICB to define common elements, such as resourcing and system-wide accountability flows and develop the system roadmap for HCP delegation.

Shadow ENH HCP Governance phases and timeline

East and North Hertfordshire Teaching NHS Trust

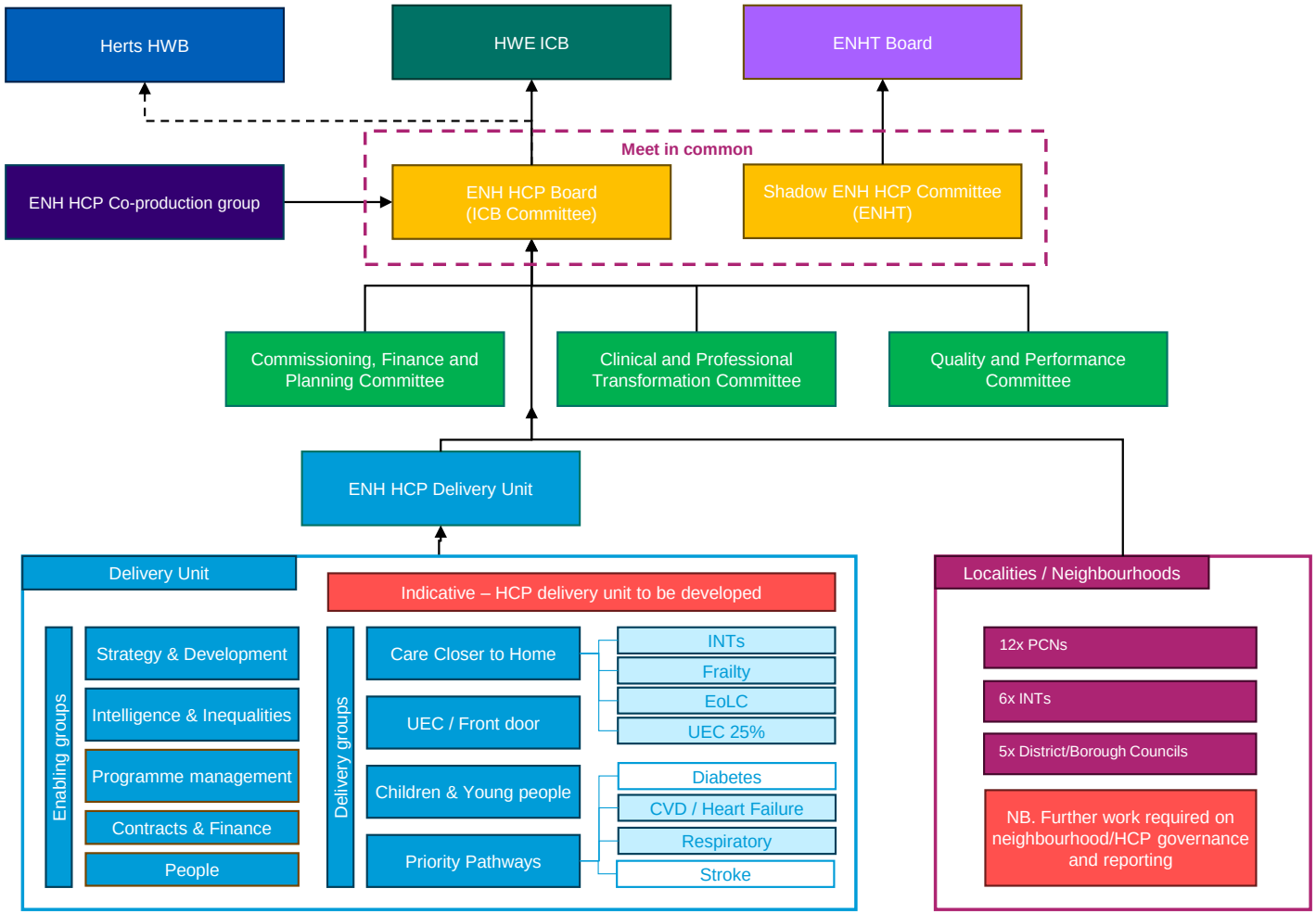
We have agreed taking a phased approach to implementing the host provider model with the ICB:

- Phase 1: From 1 July, we will move to a shadow convener 'host provider' governance arrangement.

- Phase 2: By end of November, we will agree a Delegation Agreement with HWE ICB and make necessary changes to the ENHT constitution and the HCP governance model. Our plan and approach to phase 2 will be agreed with partners through a joint project oversight group.

Shadow ENH HCP Governance structure

East and North Hertfordshire Teaching NHS Trust



Hertfordshire and West Essex Integrated Care System

NHS East and North Hertfordshire Teaching NHS Trust

East and North Hertfordshire Teaching NHS Trust East and North Hertfordshire Health Care Partnership Committee

Terms of Reference

1. Constitution

1.1 The East and North Hertfordshire Health and Care Partnership Committee ('the HCP Committee') is established by the East and North Hertfordshire Teaching NHS Trust ('ENHT') to provide strategic leadership for the East and North Hertfordshire Health and Care Partnership ('the HCP') in shadow convener form.

1.2 The ICB and ENHT are working to agree a Delegation Agreement for ENHT to become host provider and convener for the ENH HCP. To meet the ICB's expectation of moving to shadow arrangements by 1 July 2025 and start developing readiness for delegation, ENHT is establishing this non-decision-making, advisory committee. It is intended for the HCP Committee of ENHT to meet in common with the ICB's ENH HCP committee (known as HCP Board) whilst in shadow form, with the intention of the ENHT ENH HCP Committee becoming the sole committee after the Delegation Agreement has been signed and ENHT's Board approves revised terms of reference with decision-making authority for this committee reflecting the Delegation Agreement. It is intended that the creation of this committee aids the smooth preparation and transition from the HCP being a committee of the ICB to becoming solely a committee of ENHT, in ENHT's convener host capacity.

1.3 These Terms of Reference (ToR) will be published on the ENHT website and set out the membership, the remit, responsibilities and reporting arrangements of this Committee and may only be changed with the approval of the HCP Committee and ENHT Board.

2. Authority

2.1 The East and North Hertfordshire Health and Care Partnership ("the HCP") has the following vision: Working as one for healthier communities.

The role of the East and North Hertfordshire Health Care Partnership Committee ("HCP Committee") is to provide the multi-agency, system leadership to the HCP in shadow form.

2.2 The HCP Committee is authorised by the ENHT Board, and progressing the instruction of the ICB for ENHT to establish host provider shadow arrangements by 1 July, to:

- Convene and support all partners across the HCP to work together to transform health and care delivery that achieves patient-centred improvements in health and care services
- Develop and deliver the HCP's delivery plan, including relevant national priorities/ targets.
- Utilise population health management approaches, to identify and develop evidence-based pathways and models of preventive and proactive care
- Drive a fundamentally different model of care and services that support people at or closer-to-home, ensuring avoiding requirement for more costly services that may also lead to poorer outcomes and experience
- In shadow form, start working towards the fully delegated position of being accountable for balancing specified delegated budgets, and for the delivery of the relevant aspects ICBs strategy and priorities as agreed by the ICB Board.

2.3 For the avoidance of doubt, in the event of any conflict, the ENHT Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference of this HCP Committee.

2.4 For the further avoidance of doubt, whilst in shadow form prior to the signing of a Delegation Agreement, this HCP Committee has no decision-making authority and does not take on any liability or accountability.

3. Responsibilities and functions

3.1 The HCP Committee shall be responsible for transacting the HCP's core business and leading strategic thinking on behalf of the HCP in shadow form. Whilst in shadow form, the HCP committee will act in an advisory role to the ICB HCP Committee/Board. The key responsibilities the HCP Committee will be (once a delegation agreement is signed and ENHT Board approves revised Terms of Reference):

Core Business

- In shadow form, start working towards the fully delegated position of accountability for the development and delivery of the overall financial plan for East and North Hertfordshire within the specified delegated budgets of the HCP.
- To scrutinise and, after signing of the Delegation Agreement, approve recommendations proposed by the sub-committees of the Committee and associated groups, or through whatever model of managing these responsibilities the HCP agrees. This will include investment and spending decisions within the specified delegated budgets of the HCP, after signing of a Delegation Agreement.
- After signing of the Delegation Agreement and approval of revised terms of reference to become a decision-making committee, to approve recommendations for activity/interventions arising from the HCP's Clinical Transformation workstreams, the enabling workstreams and the task and finish groups.
- Receive updates from the Committee's sub-committees and to review the HCP's risk register.
- To assure and drive the performance and delivery of Integrated Neighbourhood Team transformation work in East and North Hertfordshire.

Strategic Leadership

- To participate in the development of strategy across the Integrated Care System
- After signing of the Delegation Agreement, to take joint accountability for the development and implementation of plans to transform the delivery of health and care in East and North Hertfordshire.
- To maintain oversight, understanding and alignment of individual organisation strategies and plans.
- To bring together activity, finance, operations, and quality intelligence from NHS providers in order to drive whole-system planning and prioritisation.
- To lead the resolution of strategic challenges, issues and risks between partners.

4. Composition and Quoracy

4.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	The HCP Committee will be chaired by the HCP Senior Responsible Officer (the Chief Executive of ENHT). The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.
Membership	The HCP Committee members shall be appointed by the HCP Committee in accordance with the ENHT Constitution (Standing Orders and Scheme of Reservation and Delegation). Membership shall comprise the following roles: • HCP Senior Responsible Officer (ENHT CEO) • HCT Executive representative • Non-Executive Member of the Integrated Care Board • Non-executive member of ENHT Board • Non-executive member of HCT Board • Chief Finance Officer of the ICB (or Deputy) • ICB Medical Director or Director of Nursing (or Deputy) • ICB Partner Member (Primary Care GP) • Members from partner organisations within the Health Care Partnership • East and North Hertfordshire HCP Place Director Members of the HCP Committee will operate with the individual delegated responsibility from their employing organisation to enable the Partnership to carry out its responsibilities and functions. In some circumstances this will necessitate decisions being taken through each organisation's specific governance processes. Named deputies are permitted to attend meetings where individuals above are unable to attend. When determining the membership of the HCP Committee, active consideration will be made to diversity and equality.
Attendees	Only members of the HCP Committee have the right to attend meetings, however all meetings of this Committee will also be attended by the following individuals who are not members of this HCP Committee: • SROs and programme lead(s) for transformation programmes • Specific project or programme leads from across the system • ICB/ENHT Governance lead • Secretariat

	The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.
Procedure for attendance	Where the HCP operates a HCP Strategic Finance and Commissioning Committee and its representative (who is not a member of this Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.
Meeting frequency and Quorum	The HCP Committee will meet a minimum of six times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. The ENHT Board or the HCP Senior Responsible Officer may ask the HCP Committee to convene further meetings to discuss particular issues on which they want the committee's advice. In accordance with ENHT's Standing Orders, this HCP Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. **A quorum will be at least 50% of membership**, but for decisions to be taken on delegated matters, and in line with ENHT's constitution, that must include a minimum of two members of the ENHT board or their deputies. If any member of the HCP Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Voting will be taken in according with ENHT's Standing Orders. The committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. On all matters not relating to responsibilities delegated by the ICB, all members have one vote, and a majority will be conclusive. The Chair can ask for an indicative vote of the whole Committee prior to initiating the committee voting process but this is not binding on members that will vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

5. Behaviours and Conduct

5.1 Benchmarking and Guidance

The HCP Committee will take proper account of National Agreements and appropriate benchmarking, for example Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

5.2 Values

Members will be expected to conduct business in line with the ENHT values and objectives.

Members of, and those attending, the HCP Committee shall behave in accordance with ENHT's Constitution, Standing Orders, and Conflicts of Interests/Standards of Business Conduct Policy.

5.3 Conflicts of Interest

The members of the HCP Committee must comply fully with the NHS England Guidance and ENHT's Standards of Business Conduct and Conflicts of Interest Policy.

ENHT reserves the right to ask members of the HCP Committee to provide assurance that they meet the Fit and Proper Persons criteria, before agreeing their appointment to the committee.

5.4 Equality Diversity and Inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

6. Accountability and Reporting

The HCP Committee is accountable to the ENHT Board and shall report to the ENHT Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the ENHT Board in accordance with the Standing Orders.

The Chair will provide assurance reports to the ENHT Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

7. Secretariat, Administration and Review

The HCP Committee shall be supported with a secretariat function operated by ENHT's governance team, which will include ensuring that:

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the HCP Committee is prompted to renew membership and identify new members where necessary.
Minute taking	Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the ENHT Board.
Updates	The ENHT Board is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The HCP Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

7. Sub-committees

The Committee agrees to set up the sub-committees and groups as per **Appendix A,** which the Committee may establish or vary at any point.

The sub-committee terms of reference may be approved by the HCP Committee, except where decision-making powers are conferred to the sub-committee. Authority to confer decision-making powers to a sub-committee is reserved to ENHT's Board under ENHT's Standing Orders. For the avoidance of doubt, the HCP Committee may approve the creation or disbandment of a sub-committee or revisions to sub-committee terms of reference that do not include changes to decision-making powers.

Document Control:

Version	Date	Approved By	Review	Change made
V1	30 June 2025	ENHT Trust Board	Annually	N/A

APPENDIX 3:

SUMMARY OF AMENDMENTS TO THE STANDING ORDERS AS REVIEWED BY THE AUDIT COMMITTEE

The following notable changes are proposed:

Teaching Hospital status

P.15: Amending Standing Order 2.1 (composition of the Board) to increase the number of non-executives by one, to reflect having a university representative on the Board.

Scheme of Reservation and Delegation (SoRD) amendments – policies approval

P.45: A significant overhaul of the SoRD (appendix 2) was made to the previous version. This review provided the opportunity to reflect on how the changes had embedded and identify improvements. As a result, amendments to the SoRD have been made in light of feedback from the Policy Forum/leads and relevant directors and discussed at Trust Management Group. Points to highlight:

- Having an over-arching Health & Safety policy reserved to the Board
- All other H&S/facilities and estates policies to be delegated to/reserved to Quality and Safety Committee (QSC) (previously delegated to the CEO but this adjustment is at the request of the Director of Estates)
- Medicines management and clinical competencies to be delegated to/reserved to QSC (previously delegated to non-committees, which is not in line with Standing Order requirements)
- People/workforce policies to be delegated to the Chief People Officer (CPO) and Staffside Chair (instead of the CEO), at the request of the CPO and with support of the CEO

Other amendments:

- **Minutes** (SO 3.16 P.23): – removing the need for minutes to be signed and instead just approved to reflect modern electronic practice.
- **Urgent and emergency decision-making** (SO 5.2 P.29): clarifying that such urgent decision-making can be conducted on a ‘virtual’ basis through the use of telephone, email or other electronic communication.
- **Minor non-substantive clarifying/presentational amendments** – as tracked changes.

Standing Financial Instructions (SFI) amendments

The SFIs have been updated to name latest legislation, guidance, titles and includes clarifications to aid with better reading. Substantive changes are highlighted in the table below:

APPENDIX 3:

SECTION	CHANGE	RATIONALE
3	Resource and cash limit control	Added further explanation and revenue and capital limits.
11.2.3	Prepayments section removed	Prepayments are only allowed in exceptional circumstances and the referenced calculation is outdated and not used.
15 and 15.3.12	Investment Group and Deputy Directors group changes	Investment Group has replaced Capital Review Group and the Trust no longer has a Deputy Directors Group.
15.4	Removal of PFI as a consideration when procuring	PFI are not allowed in the NHS anymore
Appendix 2B	Detailed Limits of Delegation Policy – Changes within the section - Catalogue or Non-Catalogue Orders, including Estates and Catering, once contracts have been agreed and non-purchase order invoices	To fit with the new organisational restructure

Sections 8 and Appendix 2A are currently being reviewed by the SFI sub-group of the new Procurement Act working Group and changes will be presented once these are ready.

DOC ID: Insert DOC ID

APPENDIX 4:

NHS East and North Hertfordshire Teaching NHS Trust

STANDING ORDERS, SCHEME OF RESERVATION AND DELEGATION and SFIs

About this document	
Document ID	Insert DOC ID **Version:** 15
Full review due before	31 March 2026
Document type	Constitutional Policy
Version type	Version: 15
Usage & applicability	For use by all staff and office-holders

Summary

- The Standing Orders (SOs), Scheme of Reservation and Delegation (SoRD) and Standing Financial Instructions (SFIs) form the constitution for the Trust which set out the Board and Trust corporate governance framework, including the rules for how the Trust Board and its committees operate, what powers are reserved to the Board and Committees and what powers are delegated to officers and delegation authority limits.
- All staff and office-holders must comply with these constitutional documents and all other policies in the Trust my comply with these documents. If there is a contradiction, then these constitutional documents take precedence over other Trust policies.

What you need to know about this version

- Changes to enable HCP host provider delegation from the ICB to the Trust, in first advisory, non-decision-making shadow form and then decision-making form after the Board approve the Delegation Agreement.
- Format change to new Trust policies standardised format.
- With the Trust moving to Teaching Hospital status, amending Standing Order 2.1 (composition of the Board) to increase the number of non-executives by one, to enable a university representative on the Board, in line with the revised Establishment Order.
- This is the annual review of the constitutional documents expected under the Standing Orders. A significant review and overhaul of the SoRD was made to the previous version 14, approved by the Board in May 2023.
- Amendments to the policies approval section 5 of the SoRD (appendix 2) in light of feedback from the Policy Forum and directors.
- Amendment to Standing Order 5.2 covering urgent and emergency decision-making, clarifying that such decision-making can be conducted via email.

Commented [SD1]: HCP1: Highlighting HCP Committee change

APPENDIX 4:

Document control info and governance record in “PART 4 - Document information”
Disclaimer: This document is uncontrolled when printed. See intranet for latest version.

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Part 1 – Preliminary document information

1. Scope

This document is to be used Trust-wide by all staff and office-holders.

2. Purpose

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), Scheme of Reservation and Delegation of powers (SoRD) identify who in the Trust is authorised to do what.

3. Definitions

List terms and phrases useful to know when reading this document.

Term/acronym	Definition
Accountable Officer	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.
Trust	East and North Hertfordshire Teaching NHS Trust.
Board	The Chair, officer and non-officer members of the Trust collectively as a body.
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.
Budget	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.
Budget holder	The director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the

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	organisation.
Chair of the Board (or Trust)	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.
Chief Executive	The chief officer of the Trust.
Quality and Safety Committee	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.
Commissioning	The process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
Committee	A committee or sub-committee created and appointed by the Trust.
Committee members	Persons formally appointed by the Board to sit on or to chair specific committees.
Contracting and procuring	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.
Director of Finance	The Chief Financial Officer of the Trust.
Funds held on trust	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.
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.
HCP	The Health and Care Partnership for east and north Hertfordshire place.
Member	An officer or non-officer member of the Board as the context permits. Member in relation to the Board does not include its Chair.
Associate Member	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.
Membership, Procedure and Administration Arrangements Regulations	NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.
Nominated officer	An officer charged with the responsibility for discharging specific tasks within Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions.
Non-officer member	A member of the Trust who is not an officer of the Trust and is

Commented [SD2]: HCP2: Adding HCP given it will be referenced in the document.

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	not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.
Officer	An employee of the Trust or any other person holding a paid appointment or office with the Trust.
Officer member	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).
Secretary	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 and Social Care guidance.
SFIs	Standing Financial Instructions.
SOs	Standing Orders.
SoRD	Scheme of Reservation and Delegation.
Vice-Chair	The non-officer member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

4. Duties

This document has been written by the Trust Secretary, Financial Controller, Director of Procurement and the Local Counter Fraud Specialist / Anti-Crime Specialist.

5. Associated Documents

The following documents are related Trust policies and procedural documents, which are advised reading to supplement this document and/or process. These items are different to the titles listed in Part 1 References, which contains external resources referenced in the development of this document.

Document title	Doc ID	Originator
Managing Conflicts of Interest Policy		☒ENHT | ☐Affiliated network | ☐National/ regional
Anti-Fraud and Bribery Policy		☒ENHT | ☐Affiliated network | ☐National/ regional
Trust Values		☒ENHT | ☐Affiliated network | ☐National/ regional
Code of Governance		☐ENHT | ☐Affiliated network | ☒National/ regional
Provider Licence		☐ENHT | ☐Affiliated network | ☒National/ regional
NHS Constitution		☐ENHT | ☐Affiliated network | ☒National/ regional
Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England		☐ENHT | ☐Affiliated network | ☒National/ regional
Code of Conduct for NHS Managers		☐ENHT | ☐Affiliated network | ☒National/ regional

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6. Monitoring compliance

This document will be reviewed **annually** or earlier if any evidence or change in practice comes to light requiring an update to the document. Any further activity to monitor to the use and compliance of the document at the Trust is documented below.

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
The entire document	Annually	Trust Secretary & DoF	Audit & Risk Committee and Board	None identified

6.1. Equality Impact assessment

The Trust supports the practice of evidencing due regard to equality considerations. This means those involved have ensured the document and the function, outlined therein, 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.

This evidence is in the form of an equality impact assessment (only if initial screening form below prompts a full EIA) – a process which should be embedded within the early stages of planning or developments that relate to or impact on equality diversity and inclusion. This also applies to new proposals or changes on previous policy, procedure, strategy or processes that are coming up for review. More on this process for completing Equality Impact Assessments can be found on the Equality, Diversity & Inclusion section of the intranet.

Initial EIA screening form

The document author has ensured the policy/guideline avoids affecting one group less or more favourably than another on the basis of:		Impact Yes/No	Comments
1	Age (younger people & children & older people)	No	
2	Gender (men & women)	No	
3	Race (include travellers)	No	
4	Disability (LD, hearing/visual impairment, physical disability, mental illness)	No	
5	Religion/Belief	No	
6	Sexual Orientation (Gay, Lesbian, Bisexual)	No	
7	Gender Re-assignment	No	
8	Marriage & Civil Partnership	No	
9	Pregnancy & Maternity	No	
10	Is there any evidence that some groups maybe affected differently?	No	
11	Could this document have an impact on other groups	No	

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The document author has ensured the policy/guideline avoids affecting one group less or more favourably than another on the basis of:	Impact Yes/No	Comments
not covered by a protected characteristic? (e.g.: low wage earners or carers)		
If '**NO IMPACT'** is identified for any of the above protected characteristics, then no further action is required.		
If '**YES IMPACT**' is identified a full impact assessment should be carried out in compliance with HR028 Equality & Human Rights Policy and linked to this document		
Any other comments: There is no evidence that this policy will impact on any of the protected characteristics listed above, or other groups not covered by protected characteristics.		
EIA screening form completed by: Stuart Dalton, Head of Corporate Governance **Date completed**: 06/12/2024		

6.2. Dissemination and Access

This document is considered valid when viewed via the staff intranet for East & North Hertfordshire Teaching NHS Trust. If this document is printed (in hard copy), or saved at another location, users of this document must ensure they are using the same version that is on the intranet.

7. References

Not applicable.

8. Acknowledgements

Not applicable.

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Part 2 – Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions

1. Introduction

1.1. Statutory Framework

The East and North Hertfordshire Teaching 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) as amended by The East and North Hertfordshire National Health Service Trust (Establishment) (Amendment) Order 2025 No 392, which gave the Trust Teaching Hospital status.

(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 Health and Care Act 2022 and any secondary legislation.

(3) The statutory functions conferred on the Trust are set out in the NHS Act 2006 (Chapter 3 and schedule 4) 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 Health and Care Act 2022 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 and Social Care 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

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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 the Scheme of Reservation and Delegation, the Standing Financial Instructions and the Detailed Limits of Delegation Policy 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 and Social Care on the move toward and implementation of integrated governance and other best practice guidance including the Healthy Board and the insightful provider 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 England);

(2) Up to ~~5~~ 6 other non-officer members (appointed by NHS England);

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

- the Chief Executive;
- the Director of Finance.

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The Trust shall have not more than ~~11~~ 12 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) If the Trust's Establishment Order changes the Trust's status to a Teaching Hospital, then the Trust may have 12 members and up to 6 non-officer members plus the Chair of the Trust.~~

~~2.3.~~2.2. Appointment of the Trust's Chair and Members of the Trust

Appointment of the Chair and Members of the Trust – National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and Health and Care Act 2022 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.

~~2.4.~~2.3. Terms of Office of the Chair and Members

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.

~~2.5.~~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.

~~2.6.~~2.5. Joint Members

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.

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.

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~~2.7.~~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.

~~2.8.~~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.

As Accountable Officer, the Chief Executive has the responsibilities as set out in HM Treasury Guidance Managing Public Money, including ensuring that the trust acts in accordance with Establishment Order 2000 No 535.

(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 NHS England for approval of 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.

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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.

~~2.9.~~2.8. Corporate Role of the Board

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

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

(3) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 3. A meeting in public or in private does not require the meeting to be in person. At the Chair's discretion, the meeting may be held remotely, with the public able to view the meeting online.

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

~~2.10.~~2.9. Scheme of Reservation and 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 'Scheme of Reservation and Delegation' (SoRD) 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 Reservation and Delegation.

~~2.11.~~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 and Social Care or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement ~~(e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.)~~.

3. Meetings of the Trust

3.1. Calling meetings

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

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

(3) One third or more members of the Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2. Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three clear calendar days before the meeting. Uploading the papers onto the Trust's approved Board and Committees papers online system with an email notice of

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publication will constitute service. Want of service of such a notice on any member shall not affect the validity of a meeting.

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

(3) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

(4) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair and Trust Secretary at least 15 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chair and Trust Secretary.

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

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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 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;

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- 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, Scheme of Reservation and Delegation and Standing Financial Instructions, at the meeting, shall be final.

3.11. Quorum

(1) 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.

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

(3) 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

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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.

(4) 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

(1) 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 (i.e.: the Chair of the meeting) shall have a second, and casting vote.

(2) 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.

(3) 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).

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

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

(6) 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.

(7) 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.

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

3.13. Suspension of Standing Orders

(1) 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.

(2) 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.

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

(4) The Audit and Risk Committee shall review every decision to suspend Standing Orders.

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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~~ approved 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 1960;
- Guidance should be sought from the Trust Secretary 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

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presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act 1960.

iii) **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the Board.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

iv) **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust. For the avoidance of doubt, the Trust may choose to hold the meeting remotely online and transmit and record the meeting electronically.

3.18 Observers at Trust Meetings

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

4. Appointment of Committees and Sub-Committees

4.1. Appointment of Committees

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

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

4.2. Joint Committees

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

(2) 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

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

4.3. Applicability of Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions to Committees

(1) The Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust, except where SO 4.3(ii) and 4.4(ii) apply. 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.)

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

4.4. Terms of Reference

(1) 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.

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

4.5. Delegation of powers by Committees to Sub-Committees

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.

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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 mandatory committees and joint-committees established by the Board are:

4.8.1. Audit and Risk Committee

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 Audit and Risk Committee will act as the lead oversight committee for Trust-wide corporate and strategic risk management. Other committees will support the Audit and Risk Committee through monitoring risks that fall within their remit.

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

A Remuneration and Appointments Committee will be established and constituted. The purpose of the Committee will be to make decisions on the remuneration and terms of service for the Chief Executive and other Executive Directors and those staff that are not covered by Agenda for Change or Medical and Dental Terms and Conditions; to monitor and evaluate the performance of Executive Directors and to oversee contractual arrangements, including proper calculation and scrutiny of termination payments. The Committee will also review and approve the Remunerations Framework for subsidiary companies of the Trust.

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

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.

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The provisions of this Standing Order must be read in conjunction with Standing Order 2.8 (Corporate role of the Board) and Standing Financial Instructions 29 (Funds held on Trust).

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. For the Board to consider and approve alterations to the committee structure only Standing Order 4.8, rather than all the Standing Orders, needs to be presented to the Board for approval. Approved changes will be incorporated into the Standing Orders.

These additional committees currently are:

i) **Finance, Performance and Planning Committee**

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

ii) **Quality and Safety Committee**

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

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 and Risk Committee Non-Executive Directors.

iv) **People and Culture Committee**

The purpose of the People and Culture Committee is to provide assurance to the Board on all aspects of the development and delivery of the Trust's People strategy and plans to ensure and deliver a sustainable workforce that is engaged, motivated and well supported and oversee the development and delivery of the Trust's inclusion, equality and diversity strategy.

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v) OneEPR Committee

The purpose of the OneEPR Committee is to provide assurance to the Board on the effective delivery of the OneEPR system.

vi) **Health and Care Partnership (HCP) Committee**

The purpose of the HCP Committee is to provide strategic leadership for the East and North Hertfordshire Health and Care Partnership. In advisory, shadow form, prior to the signing of a Delegation Agreement with the ICB, the committee does not have any decision-making powers, and the Trust does not take on any legal responsibility or liability during the shadow stage. However, once a Delegation Agreement is approved by the Trust Board, it is intended that the committee will move from a shadow, non-decision-making committee to become a decision-making committee and carry out the functions delegated by the ICB to the Trust as convener and host provider, on behalf of the HCP.

Commented [SD3]: HCP3: Defining the purpose of the HCP and being explicit in shadow form the committee remains non-decision-making and only the Board can approve moving to decision-making and the delegation of responsibilities and liabilities from the ICB which will be done via a Delegation Agreement. This is reiterated in the SoRD section.

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 and Health and Care Act 2022 allows for regulations to provide for the functions of Trusts to be carried out by third parties. In accordance with The Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (amended) the functions of the Trust may also be carried out in the following ways:

i) by another Trust;

ii) jointly with any one or more of the following: NHS trusts, NHS England (NHSE), Integrated Commissioning Boards (ICSs), other health bodies or local authorities;

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

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

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

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

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

5.2. Emergency Powers and urgent decisions

5.2.1 The powers which the Board has reserved to itself or delegated within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chair and Chief Executive ~~and the Chair~~ after having consulted at least two non-officer members. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification or in private session under the qualifying conditions of Section 1 (2), Public Bodies (Admission to Meetings) Act l960 (see SO 3.17).

5.2.2 In exercising emergency powers, the Vice-Chair shall be able to deputise for the Chair in the Chair's absence within the bounds of SO 2.4(3). The Deputy Chief Executive or Executive Director formally covering the Chief Executive in his/her absence shall be able to deputise for the Chief Executive but only if the matter cannot await the return of the Chief Executive.

5.2.3 Urgent or emergency decision-making may be conducted in person or on a 'virtual' basis through the use of telephone, email or other electronic communication.

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 joint committees, and their specific executive powers shall be approved by the Board in respect of its 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 Reservation and Delegation identifying his/her proposals which shall be considered and approved by the

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Board. The Chief Executive may periodically propose amendment to the Scheme of Reservation and Delegation which shall be considered and approved by the Board.

5.4.3. Nothing in the Scheme of Reservation and 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.

5.4.4. Where a function is delegated to more than one director, each director may exercise that function in respect of matters or cases falling within the remit of the directorate or team for which they are a director.

5.4.5. A delegated function must be exercised in accordance with any statutory requirement which applies to the exercise of that function. This may include duties that apply generally to the exercise of functions by public and NHS bodies, such as the duty to have regard to the NHS Constitution (section 2 of the Health Act 2009) and the Public Sector Equality Duty (section 149 of the Equality Act 2010).

5.5. Scheme of Reservation and Delegation

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

5.6. Ability to Delegate Delegated Functions

5.6.1. Only the Chief Executive may delegate matters delegated to him, whilst retaining overall responsibility. The Committees, Sub-committees, Executive and Non-Executive Members and employees to which a function has been delegated may not further delegate that function, unless specifically authorised to do so under this Scheme or as part of the delegation of that function.

5.7. 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 Audit and Risk Committee. 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

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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 Managing Conflicts of Interests Policy;
- the staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.
- Accountable Officer Memorandum
- Codes of Conduct and Accountability
- the Anti-Fraud and Bribery Policy
- NHS Constitution
- Code of Governance (on a comply or explain basis)
- Provider Licence

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, including the Detailed Limits of Delegation Policy.

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 and Caldicott Principles 2020;
- Human Rights Act 1998;
- Freedom of Information Act 2000
- Equality Act 2010
- Data Protection Act 2018

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

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a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

ii) In addition to Board Members Declarations of Interest also applies to all Directors, both Executive and Non-Executive, Senior Managers (Divisional Directors, Divisional Chairs, agenda for change band 8d and above and the Trust Secretary), Consultants and other Decision Making Staff – (all budget holders, administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions, who have the power to enter into contracts on behalf of Trust). As set out in the Managing Conflicts of Interest Policy.

7.1.2. **Interests which are relevant and material**

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

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

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

7.1.3. **Advice on Interests**

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

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

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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:

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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).

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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 and Social Care**

(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 Health and Care Act 2022 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 Health and Care Act 2022 and any secondary legislation;

for the benefit of persons for whom the Trust is responsible.

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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 of having a pecuniary interest 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
- Managing Conflicts of Interest Policy.
- Anti-Fraud and Bribery Policy
- the NHS Constitution
- Code of Conduct for NHS Managers
- the Code of Governance (except where the Trust agrees to explain in the annual report any non-compliance)

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- the Provider Licence

In addition, Board members must comply with:

- the Nolan Principles on Conduct in Public Life
- Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England

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.

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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 Detailed Scheme of Delegation Policy 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

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 Health and Care Act 2022 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 Health and Care Act 2022 and any secondary legislation.

See overlap with Standing Financial Instruction No. 21.3.

APPENDIX 4:

Part 3 – Appendices

Appendix 1 – Scheme of Reservation and Delegation (SoRD)

1.1. Purpose

To set out the powers reserved to the Board and the powers delegated to Committees and officers.

1.2. Introduction

The Code of Accountability for NHS Boards requires the Board to demonstrate the existence of comprehensive governance arrangements which may be delegated and drawn up a schedule of decisions reserved to itself and to ensure that management arrangements are in place to allow clear delegation of other responsibilities.

This document sets out the powers reserved to the Trust Board and the Scheme of Delegation. However, the Board remains accountable for all of its functions, including those which have been delegated.

All powers of the Trust which have not been retained as reserved by the Board or delegated to a Committee authorised by the Board shall be exercised on behalf of the Board by the Chief Executive. The Scheme of Reservation and Delegation (SoRD) identifies functions which the Chief Executive will perform personally and those delegated to other directors or officers. The Board reserves the ability to, at any time, withdraw the delegation of a function and exercise that function or further delegate it. The Board, in full session, may decide on any matter it wishes that is within its legal powers.

The SoRD covers only matters delegated by the Board to committees and directors. The SoRD should be read in conjunction with the Standing Orders (SOs) which sets out the operation of the Board and the Standing Financial Instructions (SFIs) which set the authorised delegated limits and thresholds.

The exercise of delegated authority must be consistent with the SOs and SFIs. In the event of any inconsistency the SOs take precedence over the SoRD and the SoRD takes precedence over the SFIs.

Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a manner that to a reasonable person is likely to be a cause for public concern and that they are exercised responsibly. The exercise of delegated authority does not obviate responsibility for ensuring that the Board and the Chief Executive are informed and where relevant involved in matters that are particularly novel, contentious or repercussive as a matter of good governance, transparency and public accountability.

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In the absence of a director or officer to whom powers have been delegated, or someone acting in a formally approved Acting Up role, those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent, powers delegated to him/her may be exercised by the Chair after taking appropriate advice from the Chief Financial Officer/Finance Director.

1.3. Scope

All Trust staff (including permanent, locum, secondee, students, agency, bank and voluntary), must follow the policies agreed by the Trust. Breaches of adherence to Trust policy may have potential contractual and contractual consequences for the employee.

In the event of an infection outbreak, pandemic or major incident, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, staff should take advice from their manager and all possible action must be taken to maintain ongoing patient and staff safety.

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1.4. Scheme of Reservation and Delegation

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
1. Regulation and Control	1.1	Approve this Scheme of Reservation and Delegation (SoRD), Standing Orders (SO's) and Standing Financial Instructions (SFI's).	✓		The scheme is reviewed by the Audit & Risk Committee.
	1.2	Suspend, vary or amend SO's, SFI's or the SoRD.	✓		
	1.3	Execute Emergency/urgent Powers reserved to the Board outside of Board meetings.		Chair and Chief Executive	At least two non-executive directors must be consulted.
	1.4	Ratify any emergency/urgent decisions of matters reserved to the Board or its Committees taken outside of Board meetings under SO 5.2. Emergency/urgent decisions must be reported to the next Board meeting.	✓		Standing Order 5.2
	1.5	Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.	✓		
	1.6	Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and on which to take appropriate action.	✓		
	1.7	Confirm the recommendations of the Trust's committees where the committees do not have executive powers.	✓		
	1.8	Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.	✓		
	1.9	Determine the Board's committee structure.	✓		
	1.10	Establish terms of reference and reporting arrangements for all committees that are established by the Board, including responsibilities (in line with legal requirements).	✓		
	1.11	Establish the structure, terms of reference and reporting arrangements for sub-committees reporting to a Board Committee (excluding executive powers which only the Board can delegate – see 1.12).		Any Committee of the Board, for their sub-committees	

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Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
1. Regulation and Control (continued)	1.12	Delegate executive powers to sub committees i.e. a committee cannot approve/delegate executive powers to one of its sub-committees without Board approval.	✓		
	1.13	Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.	✓		
	1.14	Approve the establishment of a subsidiary company and the associated articles of association and operating framework.	✓		
	1.15	Discipline members of the Board who are in breach of statutory requirements or SO's SoRD and SFIs.	✓		
	1.16	Discipline employees who are in breach of statutory requirements or SO's SoRD and SFIs.		Chief Executive	
	1.17	Monitor instances of failure to comply with SO's, SoRD and SFIs and recommend course of action where appropriate.		Audit & Risk Committee	Standing Order 5.6
	1.18	Approve detailed financial policies.		Audit & Risk Committee	
	1.19	Final authority in interpretation of SO's SoRD and SFIs.		Chair	Advised by the Chief Executive and Head of Corporate Governance
	1.20	Review decisions to suspend SO's SoRD and SFIs.		Audit & Risk Committee	
	1.21	Maintain the Register of Interests.		Head of Corporate Governance	
	1.22	Maintain an effective system of financial control.		Director of Finance	
	1.23	Approve proposed prepayment arrangements.		Director of Finance	
	1.24	Authorise the use of the seal.		Chief Executive	Standing Order 8

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Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
1. Regulation and Control (continued)	1.25	Authority to act for any matter not reserved to the Board or delegated to a Committee or officer. The Board has the authority to revert any such decision-making to the Board or a Committee.		Chief Executive	
	1.26	Compliance with the Accountable Officer Memorandum.		Chief Executive	
	1.27	Compliance with the Codes of Conduct and Accountability.	✓ (individually)		
2. Meetings of the Trust	2.1	Call Meetings.		Chair	
	2.2	Chair all Board meetings and associated responsibilities.		Chair	
	2.3	Give final ruling in questions of order, relevancy and regularity of meetings.		Chair	
	2.4	Having a second or casting vote.		Chair	
	2.5	Approve formal joint working arrangements with other organisations which involve decision-making, including established under section 75 of the 2006 NHS Act.	✓		
3. Annual Reports, Accounts and Audit	3.1	Approve the Trust's Annual Report and Annual Accounts as well as other financial statements of the Trust and any formal announcements relating to the trust's financial performance.		Audit & Risk Committee	
	3.2	Approve the Annual Report and Accounts for funds held on trust.	✓		
	3.3	Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate.	✓	Audit & Risk Committee	
	3.4	Approve the internal audit plan.		Audit & Risk Committee	

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Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
3. Annual Reports, Accounts and Audit (continued)	3.5	Approve ~~of~~ external auditors' arrangements, including a review of independence and objectivity, for the separate audit of funds held on trust.		Audit Panel	
	3.6	Review the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements.		Audit Panel	
	3.7	Review the annual management letter received from the external auditor and agree proposed action.		Audit & Risk Committee	
	3.8	Ensure an adequate internal audit service is provided by reviewing the trust's internal financial controls and internal control and risk management systems.		Director of Finance	
	3.9	Approve and review a comprehensive system of internal control, including budgetary controls, that underpin the effective, efficient and economic operation of the Trust.		Audit & Risk Committee	
4. Workforce	4.1	Appoint the Vice Chair of the Board.	✓		
	4.2	Confirm appointment of members of any committee of the Trust as representatives on outside bodies.		Chair and Chief Executive	
	4.3	Appoint and dismiss Executive Directors (subject to SO 2.2).		Remuneration Committee	
	4.4	Appoint and dismiss the Trust Secretary.		Remuneration Committee	
	4.5	Determine the broad remuneration policy and performance management framework and to set individual remuneration arrangements for the Trust's Executive Directors.		Remuneration Committee	
	4.6	Approve any termination arrangements for executive directors.		Remuneration Committee	
	4.7	Review and approve the remuneration framework for subsidiary companies of the Trust.		Remuneration Committee	

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Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
4. Workforce (continued)	4.8	Approve proposals presented by the CPO for setting remuneration and terms and conditions of employment for those employees and officers not covered by Agenda for Change or the Remuneration Committee, within agreed budgets and subject to relevant Workforce Policies.		People and Culture Committee	
5. Policies		Approval of management policies with the following reservations and delegations:			
	5.1	Policies reserved to the Board: • Constitutional policies: ~~(including Standing Orders)~~ - Standing Orders - Scheme of Reservation and Delegation - Standing Financial Instructions • Policies reserved to the Board due to their sensitivity or public relations implications: - Complaints - Risk - Freedom to Speak Up - Whistleblowing - Emergency Planning & Business Continuity - Over-arching Health & Safety (all other H&S policies are delegated to Quality & Safety Committee).	✓		
	5.2	• Financial, corporate governance (non-constitutional) and legal policies • Information Governance policies.		Audit & Risk Committee	

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	5.3	Approval of clinical, quality & safety policies including: - ~~which measure and monitor~~ clinical governance - clinical effectiveness and outcomes - research governance - health inequalities - health & safety/facilities and estates - medicines management - clinical competencies - patient and public safety - compliance with CQC regulations ~~and some workforce issues relating to workforce capability and development, such education and talent management (except where delegated to sub-committees below)~~.		Quality & Safety Committee	
	~~5.4~~	~~Medicines Management.~~		~~Therapeutics policies sub-committee~~	
	~~5.5~~	~~Competencies.~~		~~Clinical skills sub-committee~~	
	5.~~6~~4	People and workforce (HR) policies. ~~Facilities & Estates.~~		Chief People Officer with Staffside Chair~~Executive~~	
	5.~~7~~5	Any policies not expressly reserved or delegated are delegated to the ~~CEO~~Chief Executive, who may delegate to a specified officer.		Chief Executive	
	5.~~8~~6	Change to Policies so adopted shall be listed and held by the senior officer responsible for policy management.		Chief Nurse	
Policy Area	**No.**	**Decision**	**Reserved to the Board**	**Or Authority Delegated to:**	**Further Details**
6. Strategy, Plans and Budgets	6.1	Define the strategic aims and objectives of the Trust.	✓		
	6.2	Approve annual financial plan.	✓		

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	6.3	Ratify proposals for acquisition, disposal or change of use of land and/or buildings.	✓		
	6.4	Approve PFI proposals re-financing.	✓		
	6.5	Approve the opening and closing of bank accounts.		Chief Executive plus Director of Finance	
	6.6	Approve annual capital investment plan.	✓		
	6.7	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.	✓		
	6.8	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 Chief Financial Officer (for losses and special payments) previously approved by the Board.	✓		
	6.9	Approve individual patient and public compensation payments over £30k. All other compensation payments are delegated to the CEO (who may delegate further within the detailed SFIs)	✓		
	6.10	Review use of NHS Resolution risk pooling schemes (LPST/CNST/RPST).	✓		
	6.11	Approve plans for applications for short-term or longer term borrowings or loans	✓		
	6.12	Approve a list of employees authorised to make short term borrowings on behalf of the Trust (this must include the Chief Executive and the Chief Financial Officer)	✓		
Policy Area	**No.**	**Decision**	**Reserved to the Board**	**Or Authority Delegated to:**	**Further Details**
7. Quality and Safety	7.1	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.	✓		
	7.2	Approve the Trust's arrangements for handling complaints.	✓		

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	7.3	Approve the Trust's Quality Account.	✓		
	7.4	Propose arrangements for quality governance, including supporting policies, to minimise clinical risk, maximize patient safety and to secure continuous improvement and learning in quality and patient outcomes.		Quality & Safety Committee	
	7.5	Receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans.		Quality & Safety Committee	
	7.6	Monitor CNST standards and evidence compliance.		Quality & Safety Committee	
	7.7	Receive an annual self-assessment of the Trust's performance rating using the CQC's assessment framework.		Quality & Safety Committee	
8. Operational and Risk Management	8.1	Approve the Trust's policies and procedures for the management of risk.	✓		
	8.2	Approve arrangements for risk sharing and/or risk pooling with other organisations (for example arrangements for pooled budget arrangements under section 75 of the NHS Act 2006).	✓		
	8.3	Approve the Trust's counter fraud and security management arrangements.		Audit Committee	
	8.4	Approve proposals for action on litigation against or on behalf of the Trust. 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 the lead Executive Director.		Chief Executive or the lead Executive Director, with Chair of Board informed	
	8.5	Receive an annual report on litigation against or on behalf of the Trust.		Audit Committee	
Policy Area	**No.**	**Decision**	**Reserved to the Board**	**Or Authority Delegated to:**	**Further Details**
9. Monitoring	9.1	Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated and fulfilment of responsibilities.	✓		

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	9.2	Continually appraise the affairs of the Trust by means of the provision of information to the Board as the Board may require from directors, committees, and officers of the Trust, including any reporting to Board required in policies.	✓		
	9.3	All monitoring returns must be reported at least in summary to the Board, except where the Board delegates responsibility to a committee, in which case the monitoring return must be reported at least in summary to that committee.	✓	Or Lead Committee (but only where explicitly delegated in the Terms of Reference)	
	9.4	Receive reports from Chief Financial Officer on financial performance against budget and annual business plan.	✓		
	9.5	Receive reports from Chief Executive on performance matters by exception.	✓		
10. Delegated commissioning from the ICB	10.1	Approval of Delegation Agreements with the ICB.	✓		
	10.2	Delegated decision-making for matters approved within the scope of the HCP Committee within its terms of reference.		HCP Committee	
	10.3	Approval of HCP Committee terms of reference.	✓		
	10.4	Approval of terms of reference for HCP Committee's sub-committees (except delegation of decision-making powers to an HCP Committee sub-committee, which is reserved to the Trust Board).		HCP Committee	

Commented [SD4]: HCP4: Reservations and delegations explicitly set out. It is also drafted to future-proof so that the Standing Orders do not need to come back to the Board with amendments once the Delegation Agreement is approved by the Trust Board.

APPENDIX 4:

Appendix 2 – Standing Financial Instructions

1. Introduction

1.1. General

1.1.1. These Standing Financial Instructions (SFIs) are issued in accordance with the ~~Trust (Functions)~~Financial Directions~~ 2000~~ issued by the Secretary of State under the provisions of the National Health Service Act 2006 (as amended), ~~which require that each Trust shall agree Standing Financial Instructions~~ for the regulation of the conduct of the Trust ~~its members and officers~~ in relation to all financial matters~~ with which they are concerned~~. They ~~shall~~ have effect as part ~~of if incorporated in~~ the Standing Orders (SOs) of the board of the Trust.

1.1.2. These Standing Financial Instructions detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that ~~the Trust's~~its 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.

1.1.3. These Standing Financial Instructions identify the financial responsibilities that~~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. The user of these SFIs must also take into account relevant prevailing Department of Health and Social Care (DHSC) and/or Treasury instructions. All financial procedures must be approved by the Director of Finance.

1.1.4. 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.

1.1.5. 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.

1.1.6. ~~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 and Risk Committee for referring action or ratification. All members of the Board and all staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.2. Responsibilities and delegation

1.2.1. **The Trust Board**

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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.

1.2.2. 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.

1.2.3. **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.

1.2.4. 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.

1.2.5. **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;

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(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.

1.2.6. **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.

1.2.7. **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.

1.2.8. 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.

2. Audit

2.1. Audit and Risk Committee

2.1.1. In accordance with Standing Orders, the Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2024~~18~~), 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;

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(g) overseeing the LCFS function and compliance with the NHS Counter Fraud Authority NHS Requirements in accordance with the Government Counter Fraud Functional Standards.

2.1.2. Where the Audit and Risk 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 and Risk 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 and Social Care. (To the Director of Finance in the first instance.)

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

2.2. Director of Finance

2.2.1. 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 and Risk 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 and Social Care 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.

2.2.2. 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.

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2.3. Role of Internal Audit

2.3.1. 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 and Social Care.

2.3.2. 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.

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

2.3.4. The audit manager shall be accountable to the Audit and Risk 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 and Risk 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.

2.3.5. 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.

2.4. External Audit

2.4.1. The External Auditor is appointed following a selection and appointment process overseen by the 'Auditor Panel'. The Audit and Risk 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.

~~2.4.1.~~2.4.2. The Audit Partner or a representative from External Audit will normally attend Audit and Risk Committee meetings.

APPENDIX 4:

2.5. Fraud, Bribery and Corruption

2.5.1. 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.

2.5.2. The Director of Finance is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

2.5.3. 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.

2.5.4. 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, the NHS Counter Fraud Manual and the NHS Counter Fraud Authority's Investigation Case File Toolkit.

2.5.5. 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.

2.5.6. The LCFS will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit and Risk Committee.

2.5.7. 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 and Risk Committee.

2.5.8. In accordance with the ~~Raising Concerns at Work (Freedom to Speak Up)~~Speaking 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.

2.5.9. 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 and Risk Committee Chair shall sign-off the annual self-review and authorise its submission to the NHS Counter Fraud Authority.

2.6. Security Management

2.6.1. 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.

2.6.2. 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.

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2.6.3. 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).

3. Resource and cash l~~L~~imit ~~C~~control

3.1 Unless otherwise agreed, the Trust will be given an annual Revenue Resour~~cs~~e, Capital Resource and Cash Limit allocation from the Department of Health and Social Care

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3.1.1 The total revenue spending of the Trust must not exceed the total revenue resource limit control set by the Secretary of State for that year.

3.1.2. In any financial year, the total capital spending of the Trust must not exceed the total capital resource limit control set by the Secretary of State for that year.

3.1.3 In any given year the cash usage of the Trust must not exceed the cash limit (allotment) plus any payments received which are used to offset expenditure that would have otherwise scored against this limit.

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 NHS!~~Secretary of State.

~~3.~~4. Allocations, Planning, Budgets, Budgetary Control, and Monitoring

~~3.1.~~4.1. Preparation and Approval of Plan~~s~~ and Budgets

~~3.1.1.~~4.1.1. The Chief Executive will compile and submit to the Board annually a p~~P~~lan 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.

~~3.1.2.~~4.1.2. 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 a~~A~~nnual p~~P~~lan;

(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.

~~3.1.3.~~4.1.3. The Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

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~~3.1.4.~~4.1.4. All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

~~3.1.5.~~4.1.5. All budget holders will sign up to their allocated budgets at the commencement of each financial year.

~~3.1.6.~~4.1.6. 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.

~~3.2.~~4.2. Budgetary Delegation

~~3.2.1.~~4.2.1. 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.

~~3.2.2.~~4.2.2. The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

~~3.2.3.~~4.2.3. 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.

~~3.2.4.~~4.2.4. 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.

~~3.3.~~4.3. Budgetary Control and Reporting

~~3.3.1.~~4.3.1. 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;

APPENDIX 4:

(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.

~~3.3.2.~~4.3.2. 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.

~~3.3.3.~~4.3.3. 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.

~~3.4.~~4.4. Capital Expenditure

~~3.4.1.~~4.4.1. 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).

~~3.5.~~4.5. Monitoring Returns

~~3.5.1.~~4.5.1. The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

~~4.~~5. Annual Accounts and Reports

~~4.1.~~5.1. 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 Social Care and the Treasury, the Trust's accounting policies, and ~~generally accepted accounting practice~~International Financial Reporting Standards;

(b) prepare and submit annual financial reports to the Department of Health and Social Care certified in accordance with current guidelines;

(c) submit financial returns to the Department of Health and Social Care for each financial year in accordance with the timetable prescribed by the Department of Health and Social Care.

~~4.2.~~5.2. 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.

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4.3.5.3. 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 and Social Care's ~~Manual for Accounts~~Group Accounting Manual.

5.6. Bank and Government Banking Service (GBS) Accounts

5.1.6.1. General

5.1.1.6.1.1. 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 and Social Care. In line with '~~Cash Management in the NHS~~Managing Public Money' published by HM Treasury. Trusts should minimis~~z~~e the use of commercial bank accounts and only consider the use of them if the required services are not provided by ~~using~~ the Government Banking Service ~~accounts for all banking services~~.

5.1.2.6.1.2. The Board shall approve the banking arrangements.

5.2.6.2. Bank and GBS Accounts

5.2.1.6.2.1. The Director of Finance is responsible for:

(a) Establishing bank accounts operated via the Government Banking Service~~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 DHSC guidance on the level of cleared funds.

5.3.6.3. Banking Procedures

5.3.1.6.3.1. 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.

5.3.2.6.3.2. The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

APPENDIX 4:

~~5.4.~~6.4. Tendering and Review

~~5.4.1.~~6.4.1. 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.

~~5.4.2.~~6.4.2. 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.

~~6.~~7. Income, Fees and Charges and Security of Cash, Cheques and other Negotiable Instruments

~~6.1.~~7.1. Income Systems

~~6.1.1.~~7.1.1. 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.

~~6.1.2.~~7.1.2. The Director of Finance is also responsible for the prompt banking of all monies received.

~~6.2.~~7.2. Fees and Charges

~~6.2.1.~~7.2.1. The Trust shall comply with Department of Health and Social Care's ~~tariffs~~ NHS Payment Scheme in charging for activity that it has provided and follow the Department of Health and Social Care's advice in the Approved Costing Guidance~~"Costing" Manual~~ in setting prices for other NHS service agreements.

~~6.2.2.~~7.2.2. 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 and Social Care 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 and Social Care's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

~~6.2.3.~~7.2.3. 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.

~~6.2.4.~~7.2.4. 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.

~~6.3.~~7.3. Debt Recovery

~~6.3.1.~~7.3.1. The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

~~6.3.2.~~7.3.2. Income not received should be dealt with in accordance with losses procedures.

APPENDIX 4:

~~6.3.3.~~7.3.3. Overpayments should be detected (or preferably prevented) and recovery initiated.

~~6.4.~~7.4. Security of Cash, Cheques and other Negotiable Instruments

~~6.4.1.~~7.4.1. 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.

7.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

7.4.3 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.

7.4.4 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.

7.5 2003 Money Laundering Regulations

Under no circumstances will the Trust accept cash payments ~~in excess of~~more than 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.

~~7.~~8. Tendering and Contracting Procedure

~~7.1.~~8.1. General

The Trust shall use 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 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.

~~7.2.~~8.2. 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).

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~~7.3.~~8.3. Governing Public Procurement

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.

~~7.4.~~8.4. 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.

~~7.5.~~8.5. 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 NHSE~~I~~ 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 NHSE~~I~~.

~~7.6.~~8.6. Formal Competitive Tendering

~~7.6.1.~~8.6.1. 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~~SC~~);
- the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

~~7.6.2.~~8.6.2. 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.

~~7.6.3.~~8.6.3. 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);

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(b) where the supply is proposed under special arrangements negotiated by the DHSC 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.

~~7.6.4.~~8.6.4. **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.

APPENDIX 4:

~~7.6.5.~~8.6.5. **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.

~~7.7.~~8.7. Contracting/Tendering Procedure

~~7.7.1.~~8.7.1. **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 Atamis

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.

~~7.7.2.~~8.7.2. **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.

~~7.7.3.~~8.7.3. **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 Atamis.

ii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

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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. 8.6.5 below).

~~7.7.4.~~8.7.4. **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.

~~7.7.5.~~8.7.5. **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.

~~7.7.6.~~8.7.6. **Acceptance of formal tenders (See overlap with SFI No. 8.7)**

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.

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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.

~~7.7.7.~~8.7.7. **Invitation to tender – Electronic Process**

i) All tenders will be undertaken through the 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.

iii) The Director of Procurement (Hertfordshire and West Essex ICS NHS Procurement Services) as guardian for the 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 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.

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v) Acceptance of tender: If for any reason the person opening the tender is of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

vi) 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.

vii) The Director of 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.

~~7.7.8.~~8.7.8. **Tender reports to the Trust Board**

Reports to the Trust Board will be made on an exceptional circumstance basis only.

~~7.8.~~8.8. Quotations: Competitive and Non-Competitive

~~7.8.1.~~8.8.1. **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.

~~7.8.2.~~8.8.2. **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.

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~~7.8.3.~~8.8.3. **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.

~~7.9.~~8.9. 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.

~~7.10.~~8.10. 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.

~~7.11.~~8.11. 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) 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.

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(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.

~~7.12.~~8.12. 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.

~~7.13.~~8.13. 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.

~~7.14.~~8.14. 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.

~~7.15.~~8.15. In-house Services

~~7.15.1.~~8.15.1. 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.

~~7.15.2.~~8.15.2. 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.

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(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.

~~7.15.3.~~8.15.3. 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.

~~7.15.4.~~8.15.4. The evaluation team shall make recommendations to the Board.

~~7.15.5.~~8.15.5. The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

~~7.16.~~8.16. 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.

~~8.~~9. NHS Service Agreements for Provision of Services (see overlap with SFI No. 17.13)

~~8.1.~~9.1. Service Level Agreements (SLAs)

~~8.1.1.~~9.1.1. 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.

~~8.2.~~9.2. 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

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influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

~~8.3.~~9.3. 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~~The NHS Long Term Plan was published in January 2019 and set out the key ambitions for the service over the next 10 years. This set~~s~~ 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 and Health and Care Act 2022. The latest guidance can be accessed on www.england.nhs.uk.

~~8.4.~~9.4. 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.

~~9. This section is not applicable to NHS Trusts~~

10. Terms of Service, Allowances and Payment of Members of the Trust Board and Executive Committee and Employees

10.1. Remuneration and Terms of Service (see overlap with SO No. 4.8.2)

10.1.1. In accordance with Standing Orders the Board shall establish a Remuneration and 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~~ FRC guidance ~~contained in the Higgs report~~on Board Effectiveness (updated 2018).)

10.1.2. The Committee will make ~~recommendations to~~decisions on behalf of 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.

~~10.1.3. 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.~~

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~~10.1.4.~~10.1.3. 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.

~~10.1.5.~~10.1.4. 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.

10.2. Funded Establishment

10.2.1. The ~~manpower~~ staff resource plans incorporated within the annual budget will form the funded establishment.

10.2.2. The funded establishment of any department once agreed in the annual budget may not be varied without the approval of the Director of Finance.

10.3. Staff Appointments

10.3.1. 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.

10.3.2. The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees in line with national NHS and local arrangements.

10.4. Processing Payroll

10.4.1. 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.

10.4.2. 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 and Freedom of Information Acts;

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(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.

10.4.3. 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.

10.4.4. 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.

10.5. Contracts of Employment

10.5.1. 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.

11. Non-Pay Expenditure

11.1. Delegation of Authority

11.1.1. 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.

11.1.2. The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

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(b) the maximum level of each requisition and the system for authorisation above that level.

11.1.3. The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.1.4. 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 and Risk Committee.

11.2. Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 17)

11.2.1. **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.

11.2.2. **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 Trust is governed by the Public Contracts Regulations 2015. The regulations stipulates that public sector bodies must pay suppliers within 30 days.

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:

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- 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. 12.2.4 below.

11.2.3. **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)~~(a) 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)~~(b) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the ~~EU p~~Public P~~p~~rocurement ~~r~~Rules where the contract is above a stipulated financial threshold);

~~(d)~~(c) 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.

11.2.4. **Official orders**

Official orders must:

(a) be consecutively numbered;

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(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.

11.2.5. **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 p~~Public P~~p~~rocurement Regulations;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Secretary of State or Department of Health and Social Care;

(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;

ii) 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;

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(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.

11.2.6. 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.

12 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

12.3.1 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).

13 External Borrowing

13.3.1 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 and Social Care. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

13.3.2 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.

13.3.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

13.3.4 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 and Social Care.

13.3.5 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.

13.3.6 All long-term borrowing must be consistent with the plans outlined in future plans and be approved by the Trust Board.

13.4 Investments

13.4.1 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.

13.4.2 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.

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13.4.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

14 Financial Framework

14.1 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.

15 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

15.1 Capital Investment

15.1.1 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.

15.1.2 For every capital expenditure proposal (other than those described in 15.1.4 and 15.1.5 below) the Chief Executive shall ensure:

(a) that a business case (in line with the guidance issued by NHS~~I~~E on Capital Investment for NHS Trusts - Capital investment and property business case approval guidance for NHS trusts and foundation 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;

(iii) 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.

15.1.3 ~~Capital Review~~Investment 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 and revenue investment from Divisions and Corporate Directorates against risk of non-investment;

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(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) reviews 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.

~~(j)~~(k) ensures all associated revenue consequences are identified for planning purposes.

15.1.4 Business cases presented to ~~the Deputies Group~~FPPC and ~~Capital Review~~Investment 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.

15.1.5 On an annual basis the ~~Deputy Chief Operating Officer, Director of Estates and Head of IT~~Investment Group (led by the Deputy Director of Finance) collate capital requests from ~~the Clinical~~all 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~~ within the Annual Capital Programme. A schedule of approved bids will be prepared for review at the ~~Capital Review~~Investment 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.

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15.1.6 On an annual basis, the ~~Head~~ Director of Estates and Facilities produces a schedule of backlog maintenance priorities using risk-based criteria. The schedule will be prepared for review and final approval at ~~Capital Review~~Investment Group.

15.1.7 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Estatecode".

15.1.8 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~~HM Treasury guidance.

15.1.9 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

15.1.10 The Director of Finance's report to the Finance, Performance and People Committee will detail major variations to the annual capital expenditure programme.

15.1.11 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 17.6);

(c) approval to accept a successful tender (see overlap with SFI No. 17.6).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with these Standing Orders and Standing Financial Instructions.

15.1.12 ~~The Deputy Directors' Group~~Trust Management 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.~~

~~15.1.14~~15.1.13 The Finance, Performance and ~~People~~ Planning 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~~ Planning Committee will make a recommendation to the Trust Board, who will ultimately make a decision on the proposal.

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~~15.1.15~~15.1.14 Where capital schemes are in excess of the Trust's delegated limits, they will require NHS~~I~~E approval.

15.2 Private Finance (see overlap with SFI No. 17.10)

15.2.1 ~~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 ~~A~~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 and Social Care or in line with any current guidelines.

(c) The proposal must be specifically agreed by the Board.

15.3 Asset Registers

15.3.1 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.

15.3.2 The minimum data set to be held within the Trust's register shall be sufficient to identify, locate and value assets appropriately as specified in the Capital Accounting Manual as issued by the Department of Health and Social Care.

15.3.3 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 authori~~s~~zed 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) assets within lease agreements which are to be capitalised to comply with accounting standards.~~lease agreements in respect of assets held under a finance lease and capitalised~~.

15.3.4 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.

15.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

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15.3.6 The value of each asset shall be measured at its fair value in accordance with Trust's accounting policies, appropriate guidance from the Department of Health and Social Care and relevant accounting standards.

15.3.7 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, appropriate guidance from the Department of Health and Social Care and relevant accounting standards.

15.3.8 The Director of Finance of the Trust shall calculate and pay a dividend based the required return on assets in accordance with the ~~d~~Department of Health and Social Care accounting policies, currently set at 3.5%.

15.4 Security of Assets

15.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

15.4.2 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.

15.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

15.4.4 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.

15.4.5 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 and Risk Committee at least twice a year.

15.4.6 Where practical, assets should be marked as Trust property.

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16 Stores and Receipt of Goods

16.1 General Position

16.1.1 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.

16.2 Control of Stores, Stocktaking, Condemnations and Disposal

16.2.1 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 ~~e~~Estates ~~m~~Manager.

16.2.2 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.

16.2.3 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.

16.2.4 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.

16.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

16.2.6 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. 16 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.

16.3 Goods Supplied by NHS Supply Chain

16.3.1 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.

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17 Disposals and Condemnations, Losses and Special Payments

17.1 Disposals and Condemnations

17.1.1 Procedures

The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

17.1.2 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.

17.1.3 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.

17.1.4 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.

17.2 Losses and Special Payments

17.2.1 Procedures

The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

17.2.2 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 ~~H~~head of ~~D~~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 and Risk Committee.

17.2.3 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.

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17.2.4 Within limits delegated to it by the Department of Health, the Board shall approve the writing-off of losses.

17.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

17.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

17.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

17.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health. Special payments cover any compensation payments, extra contractual or ex gratia payments, and any payment made without specific identifiable legal power for the Authority to make the payment.

17.2.9 All significant losses and special payments must be reported to the Losses and Special Payments Committee who bi-annually report to the Audit and Risk Committee. Annually the Director of Finance will report all losses to the Audit and Risk Committee in support of the annual accounts approval process.

17.2.10 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 and Risk Committee on a twice-yearly basis.

17.2.11 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 and Risk Committee.

18 Information Technology

18.1 Responsibilities and duties of the Director of Finance

18.1.1 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~~2018;

(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;

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(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.

18.1.2 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.

18.1.3 The ~~Trust Secretary~~Chief Information Officer 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.

18.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

18.2.1 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.

18.3 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.

18.4 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.

18.5 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:

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(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.

19 Patients' Property

19.1 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.

19.2 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.

19.3 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.

19.4 Where Department of Health and Social Care instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

19.5 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.

19.6 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.

19.7 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.

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20 Funds Held on Trust

20.1 Corporate Trustee

20.1.1 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.

20.1.2 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.

20.1.3 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.

20.2 Accountability to Charity Commission and Secretary of State for Health

20.2.1 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.

20.2.2 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.

20.3 Applicability of Standing Financial Instructions to funds held on Trust

20.3.1 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).

20.3.2 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.

21 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 ~~2017~~ and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

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22 Payments to Independent Contractors

Not applicable to NHS Trusts.

23 Retention of Records

23.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health and Social Care guidelines.

23.2 The records held in archives shall be capable of retrieval by authorised persons.

23.3 Records held in accordance with latest Department of Health and Social Care guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

24 Risk Management and Insurance

24.1 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 and Social Care 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 and Social Care guidance.

24.2 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

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for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

24.3 Insurance arrangements with commercial insurers

24.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

(i) Trusts may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(ii) 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

(iii) 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 and Social Care.

24.4 Arrangements to be followed by the Board in agreeing Insurance cover

24.4.1 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.

24.4.2 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.

24.4.3 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 2A – 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

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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 4.

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 £ 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).

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The tender opening process will be managed by the Procurement Department. Electronic tenders will be recorded on the Atamis system and a register of tenders maintained by the Board Secretary.

Contract or purchase over OJEU limit (currently £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.

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Appendix 2B – 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	Over £5,000,001pa	Chief Executive and Director of Finance	
	Between	Director of Finance	

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organisations *	£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	
Expenditure Service Level Agreements with other NHS bodies (Clinical)	Over £50,000,001pa	Chief Executive	
	Between £10,000,001 and £50,000,000	Director of Finance	
	Between £10,001pa and £1,000,000	Deputy Director of Finance and Divisional Director	
	Up to £10,000pa	Assistant or Associate Director of Finance and Divisional Director	
Expenditure Service Level Agreements with other NHS bodies (Non-Clinical)*	Over £5,000,000pa	Chief Executive and appropriate Executive Director i.e Chief Operating Officer for Estates or Chief People Officer for HR SLAs	
	Between £1,000,001pa and £5,000,000	Director of Finance and appropriate Executive Director i.e Chief Operating Officer for Estates or	

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		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~~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	Divisional Director/Divisional	Unchanged

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	up to £50,000	Chair/Assistant 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	CUnchanged
	Over £250,001 and up to £750,000	Director of Finance	
	~~Over £100,001 and up~~Up to £250,000	~~Other~~ Voting Executive Director	
	~~Over £50,001 and up~~Up to £100,000	Deputy Director of ~~f~~Finance and non-voting Executive Directors	CUnchanged
	~~Over £10,001 and up~~Up to £50,000	Divisional ~~Director/Assistant Director of Corporate area~~Leadership Team	CUnchanged
	~~Over £5,000 and up~~Up to £2510,000	~~General Manager, Divisional Nursing Service Manager, Head of Service~~Tier one – Heads of Department / Deputy Directors	CUnchanged
	~~Over £1,001 and u~~Up to £5,000	~~Departmental head / Budget Manager (Band 8 and above)~~Tier two –	CUnchanged

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		Service Managers / Matrons / Other Clinical Directors	
	Up to £1,000	~~Budget Manager (Band 7)~~Tier three – other budget managers not picked up above	C~~Unc~~hanged
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**

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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	If these reconciled to approved payrolls as above	Deputy Director of Finance or Financial Controller	

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payments			
'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~~Investment Group will recommend the capital programme for each financial year to Executives (at TMG), who will approve this programme. Any capital expenditure outside this programme will need to be presented in a formal bid to ~~CRG~~ IG to ensure that all Estates, Equipment and IT implications have been considered before it can be ~~presented to the Exec meeting for~~ approv~~al~~ed. This includes all potential revenue schemes which have a capital implications.

Once the schemes have been approved, approval limits for orders placed will follow the revenue limits above outlined in Section 2.

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	Any	None – these require approval by HM	Unchanged

APPENDIX 4:

(discretionary)		Treasury	
Payments in connection with Employment Disputes e.g. Employment Tribunals	Over £50,001	Trust Board (or Chair and Chief Executive on behalf of the Board)	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	

APPENDIX 4:

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 and Risk 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 and Risk Committee twice yearly.		Unchanged

9. **Charitable Funds**

APPENDIX 4:

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 Director of Communications and Engagement~~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 Director (if within approved annual budget)	New limit
Other expenditure	Up to £500	~~Head of~~ Charity Director + 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.

APPENDIX 4:

Part 4 - Document record

As per policy **97 Trust policies and procedural documents**, this document is using the latest format of **Template for Trust-approved documents TMP 001.**

Document info	Doc ID: Insert DOC ID, Version – 15 STANDING ORDERS, SCHEME OF RESERVATION AND DELEGATION and SFIs This version is using TMP 001, Version date 27 December 2023
Document type	**Constitutional Policy**
Document applicability across the organisation	SELECT ONE for each of the 3 items 1. **For use** ☒Trust wide (at corporate level for both clinical and non-clinical roles); ☐ clinical cross specialty; ☐ in multiple areas (non-clinical); ☐ locally 2. **For use by** (ROLES): ☒All roles, ☐clinical roles only, ☐non-clinical roles only 3. **For use at** (SITES): ☒All sites,☐ Lister Hospital, ☐New QEII, ☐Hertford County Hospital, ☐Renal Satellite sites, ☐Mount Vernon Cancer Centre, ☐Other: **Input your selection here:** **For use by all staff and office-holders**
Review cycle	☐ Every 3 years (standard) ☒Annual review ☐ Other: **31 March 2026** **(DATE BASED ON POLICY COMPLIANCE GROUP ENDORSEMENT DATE)**
Version type	SELECT ONE ☐New document – full consultation and endorsements ☐Full review of document - various amendments/ complete re-write ☒Full review of document - minor amendments ☐Full review of document - no changes to content, still fit for use ☐Interim update - document not fully reviewed, amendments only **Version: 15** **(Interim updates permitted if review is not overdue)**
Keywords	Governance, constitution, compliance, rules, board, committee
Version author/owner	Stuart Dalton, Head of Corporate Governance, Trust Management ☐Cancer ☐Planned ☐Unplanned ☐Women & Children ☒Corporate/Directorate
Document classifications	Please select all that apply to this document ☐ **Sensitive information**: This document contains sensitive information that should not be shared outside the organisation ☐ **Public website**: this document has been selected for publication on the Trust website, maintained by the Communications Dept. ☐ **Patient Consent**: This document contains content about patient consent

APPENDIX 4:

	☐ **Forms** - This document contains forms in use at the Trust ☒ None of the above

Consultation & review

In the checklist below, the document author has considered the following **resource implications** and **impact to Trust-wide functions/services**, which also require **oversight** of local processes. Any of these listed stakeholders may also be an endorser of the final version of this document in the Record of agreement section.

If a new document, or newly amended content to this version contains processes that will have an impact on Trust functions and their users, the following actions are required.

Trust stakeholder	Action required by author
1. **Equality, Diversity & inclusion**	Trust **policies** require an Equality Impact Assessment (EIA) as evidence that the protected characteristics under Equality Act 2010 have been considered, as per Part 1, section 6.1 in this document. If the initial EIA screening in Part 1, section 6.1 determines a full EIA is required, visit the Equality, Diversity & Inclusion intranet section for next steps, which could take **3 to 4 weeks to receive approval.** EIA approval (supplied via email): Click or tap to enter a date.
2. Clinical Ethics Committee	This document may contain content that is contentious or raises moral debate. ☒No – proceed to next item ☐Yes – please see following actions **Step 1**: Seek advice from Clinical Ethics committee: ethics.enh-tr@nhs.net **Step 2**: Please provide the following info: Date of recommendations received: Were recommendations implemented and/or incorporated into document? ☐yes ☐no What was recommendation:
3. Medicines Management (Pharmacy)	This document contains processes about the use of medicines at the Trust. ☒No – proceed to next item ☐Yes – please follow these steps **Step 1**: Contact local pharmacy lead to coordinate presentation to Therapeutics Policy Committee to request their **endorsement (formal agreement the document is fit for use at the Trust)** **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders**

APPENDIX 4:

Trust stakeholder	Action required by author
	Step 3: TPC requires sign off on the final file and will be the final approver in the Record of agreement.
4. Nursing, Midwifery & AHP	This document contains processes that will have an impact on staff and care or that would affect work routines. ☒No – proceed to next item ☐Yes – please see following steps **Step 1:** For documents that are for Trust-wide use, **contact Nursing & Midwifery Excellence team** to discuss who would need to be involved in reviewing and agreeing the document is fit for use at the Trust. ☐Clinical skills group and/or ☐Clinical Board (formerly Nursing, Midwifery, AHP Quality Committee) and/or ☐The appropriate training team eg Nursing/Maternity Training Team (For documents for local use, contact in the first instance). ☐Other: **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
5. Safeguarding	This document (either for local or Trust-wide use) contains processes or information that may have an impact on children or vulnerable adults using our services. ☒No – proceed to next item ☐Yes **Step 1**: Contact **Safeguarding** team for initial discussion. **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders**
6. People (Human resources)	This document (either for local or Trust-wide use) contains processes or information about the recruitment or management of staff or other processes applicable to staff. ☒No – proceed to next item ☐Yes **Step 1**: Contact Trust Partnership committee, staff side and/or staff network groups for initial discussions. **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: In most cases, for these Trust-wide documents owned by the People team, the **Trust Partnership** requires sign off on the final file and should be the **approver** in the Record of agreement

APPENDIX 4:

Trust stakeholder	Action required by author
7. Finance	This document contains processes or information that affects the acquisition of resources (recurring or one-off) or payments of salaries or anything that has financial implications either Trust wide or locally within the Trust. ☐No – proceed to next item ☒Yes – please follow steps **Step 1**: Involve/request input from: ☐payroll, ☐local budget holders, ☐anti-fraud team Name of contact: Martin Armstrong, DoF, for the SFIs. **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
8. Estates & Facilities	This document contains processes or information about the use of Trust property or affects facilities and security on Trust premises. ☒No – proceed to next item ☐Yes **Step 1**: Involve/request input from ☐Estates ☐Facilities **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
9. Digital (IT)	This document contains processes or information about the use of Trust computer hardware, software or systems. This includes systems either managed by our local Digital team or an external supplier. ☒No – proceed to next item ☐Yes **Step 1**: Involve/request input from the appropriate team in Digital services **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
10. Senior division/ directorate staff	Document owner must apprise senior staff in their relevant area of this new or fully reviewed document. **Step 1**

APPENDIX 4:

Trust stakeholder	Action required by author
	Divisions (clinical areas): Apprise **divisional clinical governance group** of document development or send final draft for the formal meeting record and so respective the clinical director is apprised at that meeting. **Directorate (corporate/ non-clinical areas)**: Advise respective senior level group meeting of updated document so this activity is on the formal record. **Step 2** In item 11 below, record date and name of clinical governance meeting/ senior level group meeting as a stakeholder (select external). Select the activity type as "other" and indicate "for information only".
11. Document stakeholders	In the table below, please record evidence (ie date of meetings or email) of activity with departments, groups, stakeholders involved in the update/development of this document. A minimum of one stakeholder must be listed. Please delete unused rows.

Document stakeholders

Document stakeholder	Date	Activity type
Trust Management Group ☒**Internal*** ☐**External****	12-12-2024 ☒Meeting date ☐Email date	☒Content contribution ☐Read and agree fit for use ☐Other:
Audit and Risk Committee ☒**Internal*** ☐**External****	14-01-2025 ☒Meeting date ☐Email date	☐Content contribution ☒Read and agree fit for use ☐Other:
Trust Board ☒**Internal*** ☐**External****	12-03-2025 ☒Meeting date ☐Email date	☐Content contribution ☐Read and agree fit for use ☒Other: Approval

***Internal** – a stakeholder within document author's dept/service/area – a service manager, team meeting, etc.
****External** - a stakeholder outside of dept/service/area or outside the organisation

☒At least one of the above in the consultation list is a formal endorser in the Record of agreement. NOTE: An endorser and/or approver may request evidence of consultation (with any of the above or others not mentioned) before their sign off is granted.

Other consultation and stakeholder actions required

Not applicable

APPENDIX 4:

Record of agreement

Full details of the **endorsement and approval process** can be found in policy **97 - Trust policies and procedural documents**.

DOC ID & title	Insert DOC ID, Version: 15 - STANDING ORDERS, SCHEME OF RESERVATION AND DELEGATION and SFIs
Due date of next full review	31 March 2026
Document type	Constitutional Policy
Version type	Version: 15
Applicability	For use by all staff and office-holders
Version author	Stuart Dalton, Head of Corporate Governance, Trust Management
Legacy ID	

Endorsement	Record of formal agreement this version is fit for use at the Trust by the Audit and Risk Committee in meeting minutes/ meeting action log of under item Standing Orders, held on 14/01/2025.
Approval	Upon considering the above endorsements, the approver, the Trust Board agrees this document is fit for use at the Trust. Confirmation of this agreement is in meeting minutes under item Standing Orders, held on 12/03/2025.
Trust endorsement	Record of formal agreement this version is fit for use at the Trust by Policy Compliance Group under agenda item [insert relevant item number] at meeting held on YYYY-MM-DD **For completion by Policies Compliance Group**
Governance checks	ADMIN USE ONLY

*Types of approvers (as per policy 97):

- A member of senior leadership or divisional triumvirate, a Trust committee/group or Trust function stakeholder (including name, role, dept) can approve a fully reviewed and endorsed document.
    - The Trust delegation of standards cites specific policies that require board approval.
- A head of service, or stakeholder or committee chairperson (usually endorser listed at the last full review) can approve an interim update of a document.
- A head of service or department can approve documents for local use only (for all version types).
- All policies require “Trust endorsement” from the Policy Compliance Group.

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	4	
Report title	Quality Account 2024/2025		**Meeting Date**	30 June 2025	
Author	Associate Director of Quality Governance				
Responsible Director	Director of Quality Chief Nurse				
Purpose	**Assurance**	☒	**Approval/Decision**	☒	
	Discussion	☒	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☒	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

The Quality Account 2024/25 demonstrates reasonable assurance through comprehensive reporting of quality priorities, achievements, and areas for improvement.

While significant progress has been made across multiple domains, some targets remain unmet, requiring continued focus and improvement actions.

Summary of key issues:

Impact: *tick box if there is any significant impact (positive or negative):*

Patient care quality	☒	**Equity for patients**	☒	**Equity for staff**	☒	**Finance/ Resourcing**	☐	**System/ Partners**	☒	**Legal/ Regulatory**	☒	**Green/ Sustainability**	☐

- Trust achieved 4th most improved position nationally in staff survey
- Successful implementation of PSIRF with 20% increase in incident reporting
- Maternity services named most improved Trust in CQC governance survey
- Challenges remain in complaint responsiveness and some operational targets
- New quality priorities established for 2025/26 aligned with Trust strategic goals
- Document requires Board approval before publication

Trust strategic objectives: *tick which, if any, strategic objective(s) the report relates to:*

Quality Standards	☒	**Thriving People**	☒	**Seamless services**	☒	**Continuous Improvement**	☒

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

N/A

Report previously considered at & date(s):

Considered at the Trust Management Group- 1st scrutiny and agreement- 12 June 2025
Was presented at the Quality and Safety Committee – 25 June 2025

Recommendation	Final approval and publication at the Public Trust Board.

To be trusted to provide consistently outstanding care and exemplary service

June 2025

East and North Hertfordshire Teaching NHS Trust

Quality Account 2024-2025

Contents

Part one

1.1 Chief Executive's Foreword

It has been a challenging 12 months, both for our Trust, and in the wider NHS and health landscape. However, the following quality accounts show that there is much to be proud of.

Earlier this year, our application to be recognised as a teaching trust was approved by the Department for Health and Social Care. This change reflects the immense hard work that happens day in and day out, to ensure all our students and trainees receive high quality education.

After the launch and implementation of the ENH production system, our patient-centred partnership with Virginia Mason Institute, I am pleased to report that 731 staff (0ver 10% of our workforce) have completed the introduction course. This is already having an instrumental impact on patient care and will be an important step in quality improvement both now and in future years.

After successfully transitioning the patient safety incident response framework (PSIRF) back in 2023, a programme that was co-designed with patients and carers, we have seen a 20% increase in incident reporting. This increase indicates a much-improved safety and learning culture. We know that any safety incident is one too many, however the standardisation, oversight and governance have seen a vast improvement and increase in good care reporting, as well as a reduction in the number of overall risks.

Patient care and accountability is the main aim across the trust. A key focus area has been adult and paediatric deteriorating patients, and we are proud to have embedded Marthas Rule (MR) and Call4Concern more widely into our everyday practice.

100% of MR calls were actioned with an in-person clinical assessment and we were ranked third in the region for the volume of MR activation calls. This is all down to effective communications and emphasises the uptake of the escalation process.

As always, as vital and rewarding as these successes are, there are still areas where we need to improve.

Patient waiting times remain an area of focus. As does the need to develop targeted services to better understand and meet the needs of those with learning disabilities.

As a trust, we are dedicated to working on these improvements and I'd like to take this opportunity to thank all those who have worked hard to ensure we continue to provide high-quality compassionate care for our communities.

Performance overview

1.2 Accountability for quality: how we hold ourselves accountable

The Quality Account is a mandatory document required under the Health Act 2009 and subsequent regulations (Health and Social Care Act 2012, and the National Health Service (Quality Accounts) Regulations 2010) which serves as a key accountability mechanism. The Quality Account is therefore a key mechanism that provides demonstrable evidence of measures undertaken in improving the quality of the Trust's services.

As part of the development of the Quality Account all NHS Trusts are required to identify measurable priorities mapped against Darzi headings of Safe, Effective and Patient Experience.

This document serves multiple functions:

- Demonstrates quality improvements and achievements
- Identifies areas requiring further development
- Maps priorities against the Safe, Effective and Patient Experience framework
- Promotes quality improvement across the NHS
- Enhances public accountability
- Facilitates stakeholder engagement and feedback

The Trust's overall vision is to be trusted to provide consistently outstanding care and exemplary service. We will deliver our vision by focusing on our strategic themes - quality, thriving people, seamless services, and continuous improvement which will in turn support operational performance.

1.2.1. Our Strategic Goals

In 2024/25, our strategic goal was to deliver safer, more efficient, and compassionate care by embedding continuous improvement across all levels of the organisation. This included a commitment to zero harm, empowering staff through leadership and improvement capability, working in partnership to enhance services, and making best use of our resources.

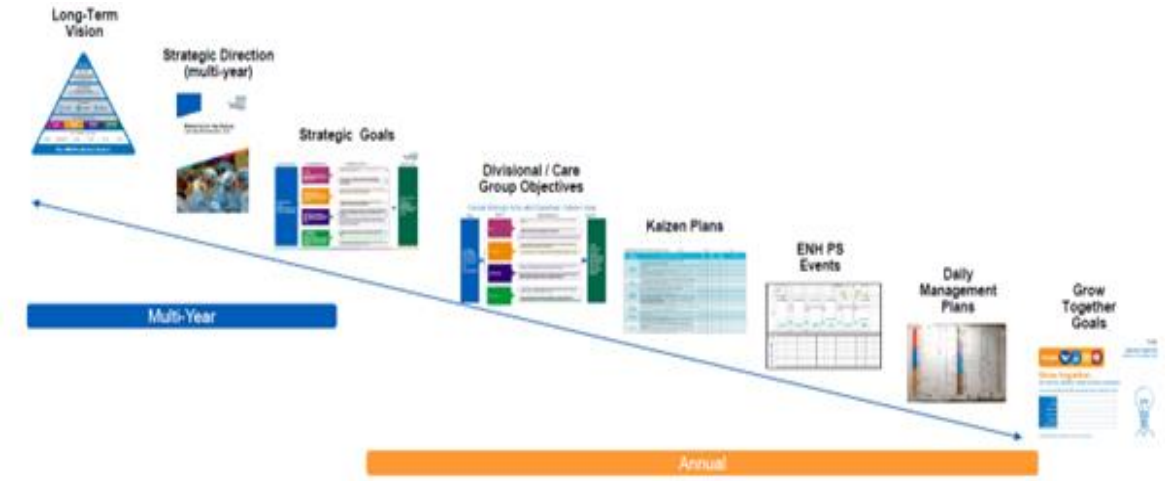


Fig:1: Strategic goal cascade from vision to individual grow together conversations

We are achieving this through a range of initiatives—from large-scale cross-functional transformation programmes to small, team-led daily improvements. Key activities in the last year have included rapid process improvement workshops, a new senior leadership development programme, the formation of an Acute Provider Collaborative to improve care and efficiency across partner trusts, and wide-scale staff training in waste reduction and lean methodologies.

For 2025/26, as a Trust, we have agreed moving away from narrow, targeted annual objectives to broader, multi-year strategic goals designed to drive meaningful, long-term transformation. This shift enables teams to better align their work and resources with the Trust's overarching priorities.

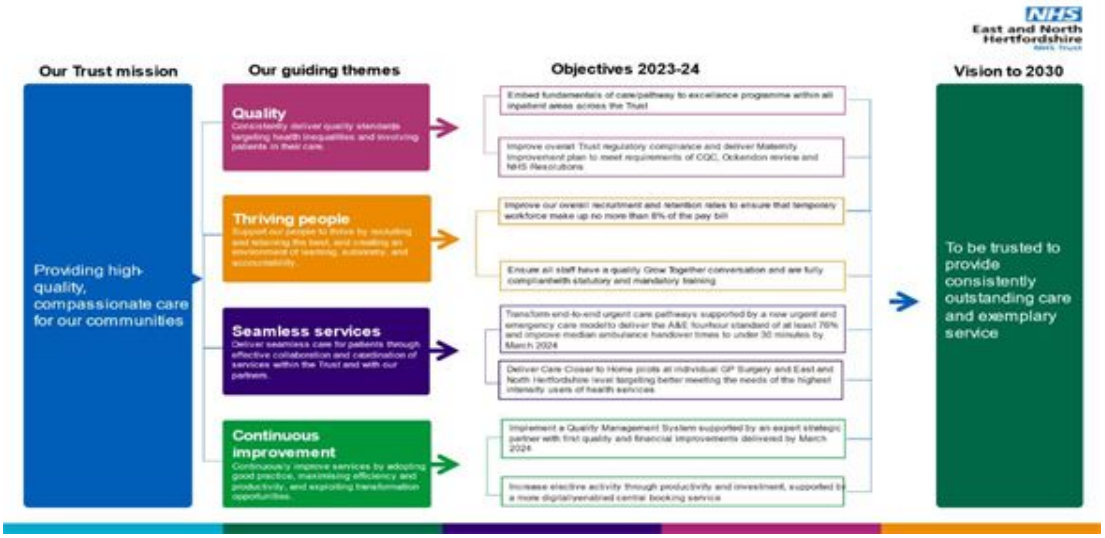


Fig 2: East and North Hertfordshire 2025/26 strategic goals

Our strategic goals for 2025/26 will focus on transforming care quality through innovation, particularly via the rollout of a new unified Electronic Patient Record (OneEPR). This digital transformation will streamline outpatient services, improve access and choice for patients through a dedicated portal, and introduce artificial intelligence to optimise scheduling and reduce waiting times.

We are also strengthening our commitment to inclusive leadership and workforce wellbeing through the delivery of a new EDI strategy and the ongoing expansion of our Healthy Teams framework and staff networks.

To ensure services are shaped by the people who use them, we are enhancing patient and community engagement, working with local partners to integrate insights into planning and embedding co-production into all improvement activities.

Through these strategic goals, we aim to deliver high-quality, efficient, equitable care by empowering our teams, improving patient experience, and embracing digital innovation.

1.2.2. ENHT Organisational Structure

The Trust operates with four clinical divisions (Women & Children, Planned Care, Unplanned Care, and Cancer Services), each led by a triumvirate structure of divisional medical director, nursing/quality director, and operations director.

This structure extends to the specialty level. Supporting corporate teams cover finance, digital, medical practice, education, estates, transformation, and workforce development.

The organisation is strengthened by its established people strategy (2020) built on work, grow, thrive, and care pillars, which continues to effectively support strategic priorities through integrated plans aligned with NHS workforce requirements.

1.2.3. Clinical and Quality Strategy

Our Quality Strategy has continued to support the continuous improvement journey toward an ‘East and North Herts Trust' quality management system. The successful procurement of a single Improvement Partner will enable a systems approach to manging quality. These will continue to build on the current quality objectives (see below).

Understand where variation exists and use data to proactively drive improvement by reducing the ‘unwarranted variation and strengthening ward to board oversight of quality fundamentals of care

To foster a culture where staff can generate ideas, lead improvement efforts, feel valued and confident to influence the care they deliver. Driving continuous improvements through Patient Safety Symposiums and learning through multidisciplinary simulation.

To enable our people with skills and knowledge that strengthens their craftsmanship and expertise to execute their work well by delivering a ENHT Accredited Human Factors curriculum and leadership development programme.

To prioritise and understand what matters to staff, patients and carers who experience our organisation. Improving responsiveness to staff patient and family experience through SWARM processes and real time feedback.

1.2.4. Quality Governance

The Chief Nurse and Medical Director serve as Trust Executives for Quality. The Board delegates quality oversight to the Quality and Safety Committee (QSC) and Trust Audit and Risk Committee.

The Trust operates a comprehensive "ward to board" quality governance framework featuring regular self-assessments and division-led evidence stacks providing annual CQC well-led domain assurance.

Key Components:

- Quality Governance Standards Framework programme
- Patient Safety Incident Response Framework (PSIRF) with defined roles and clinical risk identification
- Culture of openness and organisational learning via QSC
- CQC standards compliance monitoring with performance review meetings
- Annual Report quality priority determination

The Trust recognises that robust systems cannot capture all issues in complex healthcare environments and continues working to triangulate data, minimise unexpected issues, and address governance non-compliance.

Part two: Priorities for improvement and statements of assurance from the board

2. Progress with 2024/2025 priorities

As a Trust, we set out clear priorities for improvement last year that reflected both our local challenges and national ambitions for safer, more effective, and person-centred care. Presented below is a summary of how we have performed against those commitments highlighting areas we have made meaningful progress – from embedding a culture of learning and improvement to strengthening safety systems, enhancing patient experience, and leading with greater accountability. These outcomes are the result of collective effort across our teams, and they provide a strong foundation for the year ahead.

Effective: The Trust advanced digital capability and quality oversight through the implementation of the 'Enhance' platform, enabling real-time, ward-to-board triangulation of incidents, risks, complaints, NICE compliance, and quality indicators.
Quality Improvement (QI) capacity was strengthened through ENHPS training, with 731 staff trained and 42 leaders completing the intensive leadership programme, establishing a strong base for quality improvement. The PSIRF framework was embedded, enabling thematic reviews and capturing 582 episodes of good care. These efforts represent progress toward a sustainable, data-driven improvement culture.

Patient Experience: The Trust was named the most improved Trust in the 2023 CQC governance maternity survey, performing significantly better in 15 areas. The Patient and Carer Experience (PACE) Programme, co-designed post-incident support, and discharge planning improvements helped embed personalised care. Specific equity actions in paediatrics and maternity contributed to service redesign that focused on continuity and accessibility. These were supported by increased responsiveness to complaints and sustained patient engagement.

Safe: The Trust published and implemented its Patient Safety Incident Response Plan and Policy, meeting national safety standards and embedding the Learning from Patient Safety Events (LFPSE) system. A 20% increase in incident reporting and improved thematic reviews reflect an enhanced safety culture.
Medicines optimisation and infection control saw improvements, including a reduction in C. difficile infections to 86 cases (6.5% improvement), near-target performance on antimicrobial stewardship reviews, and high IPC training compliance.
Safeguarding referrals rose due to improved staff awareness and training. In addition, Martha's Rule was implemented Trust-wide, providing a clear escalation route for patients, families, and staff to raise concerns about deterioration. Collaboration with regional and national partners supported shared learning, with early impacts including ITU interventions and improved responsiveness to concerns. Work continues to address equity of access and embed patient wellness checks into routine observations through the EPR.
Sepsis pathway compliance continues to be an improvement priority although there is sustained increase in compliance year on year.

Well-Led: Governance maturity was reinforced by a comprehensive good governance review, redesign of the risk management approach, and implementation of a new strategy. The risk register saw a 14% reduction in open risks, supported by improved triangulation of feedback, incidents, and board-level risk escalation. Staff engagement and psychological safety improved, with national recognition as the 4th most improved Trust in the 2024 staff survey. Speak Up systems saw a 15% year-on-year rise in concerns raised, with 87% of staff completing Speak Up training.

2.1.1. Quality Priorities 2024 to 2025				
Domain	**Description**	**Key Focus Areas**	**How we Measured Success**	**Achievements to Date**
Effective	**Priority 1: Build quality improvement (QI) capability and capacity** Good governance • Excellent responsiveness to incidents • Learning from incidents Reason: Adoption of quality improvement to become an integral part of everything we do requires an infrastructure that supports all staff.	Digital transformation	**Staff Training Engagement**: ENHPS training program launched, with 731 staff (10.3% of workforce) completing the introduction course and 42 senior leaders participating in the intensive leadership program, demonstrating strong initial adoption that establishes the foundation for our quality management transformation.	• Successfully embedded East and North Hertfordshire Production System (ENHPS) in partnership with Virginia Mason Institute with a fully staffed office complement. • Implemented methodologies for both daily quality management & continuous improvement using kaizen principles.
		Ward to board assurance of Patient Safety Incident Response Framework (PSIRF) safety standards	• Increased Incident reporting rates with substantial year-on-year improvement. • Increased number of good care reporting across the Trust. • Thematic reviews to identify cross-cutting learning opportunities across specialties	• Successfully transitioned to the Patient Safety Incident Response Framework (PSIRF) in November 2023, with Board-approved Policy and Plan • Achieved 20% increase in incident reporting (16,502 in 2024/25 vs 13,767 in 2023/24), demonstrating enhanced safety learning culture. • Implemented Learning from Patient Safety Events system, capturing 582 "good care" events in 2024/25 • Commissioned 17 Patient Safety Incident Investigations, supporting thorough safety reviews and systemic learning

Plans for 2025/26- EFFECTIVE:

- Embed PSIRF through agile development of our incident reporting system to support real-time ward-to-board oversight, internal monitoring, and national reporting.
- Expand thematic reviews and standardised learning, applying a systems approach to cross-cutting safety risks and supporting directorates with targeted improvement pathways.
- Grow leadership capability in quality improvement, increasing participation in the ENHPS for Leaders programme from 60 to 90 and embedding QI methods across divisions.
- Deliver our digital transformation roadmap, completing the OneEPR rollout, implementing AI-supported waiting list optimisation, and launching patient portal access as part of outpatient redesign.
- Advance our equity and inclusion goals, ensuring the EDI strategy is embedded through the Trust's EDI Steering Group and integrated into all improvement workstreams.

Progress against these priorities will be tracked through the Trust's Quality & Safety Committee, Risk and Audit Committee, and Divisional boards

** Pathways to Excellence: Following a strategic review, the Trust is refreshing the framework in which this strategy will be integrated going forward. A data-driven Pathways to Excellence Framework—now a 2025/26 strategic priority—will be co-design to deliver an aggregated recognition table to ensure sustainable improvement in quality standards. **

2.1.2. Adult and paediatric deteriorating patients (including sepsis)

<table>
<tr><th>Domain</th><th>Description</th><th>Key Focus Areas</th><th>How we Measured Success</th><th>Achievements to Date</th></tr>
<tr><td rowspan="2">Safe</td><td rowspan="2">Valuing the basics: Keeping our patients safe</td><td>Adult and paediatric deteriorating patients (including sepsis)</td><td>Achieve >95% in sepsis pathway compliance
Achieve 50% compliance with reliability of all observations
Improve physiological observation assessment competencies for nursing staff.</td><td>Sustained increase in sepsis compliance performance year on year.
<table>
<tr><th>Sepsis pathway compliance</th><th>Achieved 23/24</th><th>Achieved 24/25</th></tr>
<tr><td>Antibiotics in Emergency Department (ED) within an hour</td><td>83%</td><td>89%</td></tr>
<tr><td>Antibiotics on the ward within an hour</td><td>64%</td><td>82%</td></tr>
<tr><td>Neutropenic sepsis antibiotic within an hour</td><td>67%</td><td>88%</td></tr>
<tr><td>ED Sepsis six bundle</td><td>60%</td><td>74%</td></tr>
<tr><td>Inpatient (IP) Sepsis six bundle</td><td>37%</td><td>56%</td></tr>
</table></td></tr>
<tr><td>Documentation – adopt new documentation standard to include SBARD Tool (Situation, Background, Assessment, Recommendation, and Decision)</td><td>Improved communication and escalation for deteriorating patients
Simulations training</td><td>SBARD week held to promote use of the communication tool.</td></tr>
</table>

		National pilot for Martha's rule and imbed call for concern	• Full implementation of components 2 and 3 (escalation routes for staff, patients, and families) across all inpatient wards, maternity, paediatrics, and ED • Pilot of component 1 (patient wellness question) in one ward area, with ongoing collaboration on data collection • Volume of Activation Calls • Clinical Outcomes & Interventions arising from the use of Martha's rule • Equity & Inclusion Insight using demographic data • Process improvements	• 100% of Martha's Rule calls received in-person clinical assessments, resulting in 25% ITU reviews, 48% of patients remaining under CCOT review for over 48 hours, and one patient (100% of applicable cases) directly transferred to ITU as a result of a family-initiated escalation. • Full rollout of MR escalation routes (components 2 & 3) across all key clinical areas. • Ranked third in the region for the volume of Martha's Rule activation calls, indicating effective uptake of the escalation process. • Active participation in regional and national learning collaboratives. • Progress towards integrating MR into digital systems (OneEPR), Enhance for data triangulation with incidents and complaints. • Identified areas for improving equity of access to MR, guiding future improvement work.

Plans for sustainability 2025/26:

Sepsis:

- Sustain and Improve current improved sepsis bundle compliance and target further incremental improvements.
- Improve fluid balance documentation compliance by +10% from current baseline by Q4.
- Enhance clinical knowledge and practice through continued multi-disciplinary sepsis education.

SBARD Tool:

- We will continue to deliver targeted training on communication and escalation protocols to ensure effective embedding into practice.

Martha's Rule: Call for Concern:

- Strengthen acute patient care capacity by supporting enhanced care beds, implementing a Hospital at Night model, merging Sepsis and CCOT teams into an Acute Response Team, and expanding paediatric response capabilities.

2.1.3. Medicines management and antibiotic stewardship

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Safe	**Priority 2: Keeping our Patients Safe.** Valuing the basics: Keeping our patient's safe Reason: Part of our quality goals within the Trust's quality strategy- valuing the basics and keeping our patients safe (2019-2024)	Medicines management and antibiotic stewardship	• Implementation of Trust's medicines optimisation strategy (100%) • Improve critical medicines omission rate ≤3.5% • Antimicrobial stewardship 24-72-hour review compliance ≥90% • Medicines management training completion >90% • Maintain pathway compliance rates >90% across all departments • Increase audit sample sizes by 300% during focused review periods	• 100% implementation of Trust's medicines optimisation strategy, including development of Power BI KPI dashboard and ePMA benefits realisation. • Achieved critical medicines omission rate of 3.9%, slightly above target of ≤3.5% due to staffing challenges and winter pressures • Attained 84.8% compliance with antimicrobial stewardship 24-72-hour reviews, approaching but not meeting 90% target. • Implemented weekend reviews of high-risk antibiotics, significantly reducing incidents related to monitoring of complex antimicrobials • Achieved 74% completion rate for medicines management training (doctors, nurses, pharmacists), below >90% goal • Successfully implemented anticholinergic burden identification system supporting ICB de-prescribing initiative • Developed manual prioritisation system for ward-based pharmacy teams and built additional Lorenzo ePMA order sets

Plans for sustainability 2025/26:

- We will continue to focus on implementing the integrated Orbis U system, enhancing electronic prescribing capabilities, improving training compliance to 90%, strengthening antimicrobial stewardship, optimising discharge procedures, and standardising cross-departmental audit methodologies to address identified performance gaps while maintaining our achievements in medicines optimisation and pathway safety.

2.1.4. Infection prevention control (IPC) – C.Diff improvement programme

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Safe	**Priority 2: Keeping our Patients Safe.** Valuing the basics: Keeping our patients' safe	Infection prevention control (IPC) – C.Diff improvement programme	• C. difficile infection threshold ≤92 cases for 2024/25. • MRSA bacteraemia threshold of 0 cases • Carbapenems Producing Organisms threshold of 0 cases • E. coli blood stream infections threshold ≤55 cases. • Pseudomonas aeruginosa BSI threshold ≤12 cases • IPC Level 1 and Level 2 e-learning sessions completion rates (target >90%)	• Successfully implemented peripheral intravenous cannulation competency program. • Reduced C. difficile infections to 86 cases (6.5% reduction from 2023/24) against threshold of 92. • Established weekly C. difficile MDT meetings led by Medical Director or Chief Nurse • 99% of hospital onset C. diff cases reviewed (deemed clinically unavoidable) • Achieved 98% completion of IPC training (up from 93% last year) • Improved antimicrobial stewardship with enhanced 24-72 hour review processes. • Reduced E. coli BSI by 9% compared to previous year (52 cases vs. threshold of 55). • Limited MRSA bacteraemia to 2 cases for 2024/25

Plans for sustainability 2025/26:

- Maintain weekly C. difficile MDT reviews to sustain reductions in infection rates.
- Extend our Aseptic Non-Touch Technique competency training program to all clinical areas and embed into routine practice.
- Continue collaborative work with specialty teams to refine post-infection learning and strengthen PPE training for high-risk pathways

2.1.5. Safeguarding oversight

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Safe	**Priority 2: Keeping our Patients Safe.** Valuing the basics: Keeping our patients' safe	Safeguarding oversight and triangulation with other domains of quality	• Increase in safeguarding referrals through enhanced awareness & training • Increased safeguarding training compliance with intercollegiate document standards • Improved outpatient attendance for patients with learning disabilities	• Achieved historic high levels of safeguarding referrals for both adults and children likely due to enhanced awareness/identification by staff teams. • Maintained Trust Domestic and Sexual Abuse Team (DSAT) supporting almost 600 victims. As a result of our work, the Police and Crime Commissioner's office has extended the DSAT service grant through to the end of the 2025/26 financial year due to its demonstrated success. • Completed 815 Deprivation of Liberty Safeguards applications (8.1% increase from previous year) • Increased attendance rates for patients with learning disabilities through 'was not brought initiative' • Ensured all safeguarding policies are in date and ratified

Plans for sustainability 2025/26:

- We will continue and expand the DSAT service under extended funding through 2025/26.
- Enhance training on safeguarding recognition and escalation for all staff.
- Develop targeted services to better meet the needs of individuals with learning disabilities and autism
- Strengthen our collaborative work with external safeguarding MDT

2.1.6. Invasive procedures LocSSIP Compliance

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Safe	**Priority 2: Keeping our Patients Safe.** Valuing the basics: Keeping our patients' safe	Invasive procedures LocSSIP compliance across non theatre specialties	• Compliance Percentage Tracking: Average compliance rate of > 92% across all audited patient pathways. • Quality and consistency of safety checks in Local Safety Standards for Invasive Procedures (LocSSIPs) • >95% department participation rate in pathway safety monitoring • >90% adherence to standardised documentation across all clinical areas.	• Achieved sustained compliance rates of >90% across patient pathway audits for 95% of measured time periods. • Expanded monitoring coverage by 300% in specialised departments (Ophthalmology, Radiology) compared to baseline with focused quality improvement initiatives. • Improved data collection with 400% larger sample sizes (from ~35 to ~140) during focused audit periods. • Demonstrated 100% implementation of standardised audit methodology across all six clinical areas which reflects a consistent audit approach shown across all departments. • Maintained >95% compliance in documentation standards during peak activity periods.

Plans for sustainability 2025/26:

- We will conduct a comprehensive review of all sites delivering invasive procedures.
- We will conduct focused audits to assess both the quality of LocSSIPs and the consistency of their application in practice
- Establish a cross-departmental learning framework to share best practices and address variation

2.1.7. End of life care – Gold Standards Framework (GSF)

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Safe	**Priority 2: Keeping our Patients Safe** Valuing the basics: Keeping our patients safe	End of life care – Gold Standards Framework (GSF)	• Completion of GSF implementation phases and accreditation • Staff confidence questionnaires pre and post training • After Death Analysis Audit Tool to track preferred place of death achievement • Assessment of Advanced Care Planning documentation completion rates • Number of staff and wards trained in GSF principles	• Successful integration of 7 key GSF outcomes in clinical practice across trained wards • Successfully implemented a phased GSF approach with Phase I completed and accredited (September 2023) • Phase II completed and accredited (September 2024) covering 4 wards (5b, 10b, Ashwell & Pirton) • Phase III implementation completed covering 4 wards (Barley, CCU, 9a, 9b), currently awaiting accreditation • Trained minimum of 2 staff per ward across 10 wards to date (Phase I-III) • Implemented systematic identification of patients in last year of life using Surprise Question approach • Established Advanced Care Planning conversations as standard practice • Improved documentation of patient preferences including preferred place of death • Enhanced staff confidence in end-of-life care delivery through structured training

Plans for sustainability 2025/26:

- We will complete the implementation of Phase IV (commenced April 2025) covering 4 additional wards (10a, 8a, 6b, 7a) with e-portfolios submissions & continuous training through March 2026 to embed principles
- We will continue systematic monitoring of Advanced Care Planning completion and preferred place of death achievement
- We will support wards with GSF Gold Standard Accreditation to maintain standards for 3-year accreditation period
- We will prepare phase I wards for potential Platinum status accreditation
- We will further embed GSF principles to ensure sustainability despite staff turnover & participate in completing national GSF team assessment visits for Phase IV wards.

2.1.8. Medical devices – improved EBME service and equipment library.

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Safe	Valuing the basics: Keeping our patients safe	Medical devices – improved EBME service and equipment library	• Improved inventory oversight (through systematic tracking of medical devices, enabling real-time visibility of usage, maintenance needs, and availability. • Maintenance logs compliance monitored via logged service records, ensuring timely and documented completion of device servicing. • Digital enhanced safety assurance by tracking completion rates of compliance checks and certification renewals, supporting regulatory readiness. • Incident reduction and learning by using ENHance to analyse year-on-year trends and drive safety improvements. • User-informed improvement through regular collection & review of feedback to guide device-related enhancements and training.	• Achieved 93% service compliance and 90% repair compliance for hospital equipment in FY 2024–25, with strategies in place to further improve scheduling and tracking • 15.24% of medical devices (2,515 of 16,492), RFID-tagged and audited with full completion targeted by year-end. Tracking scanners are being integrated into the IT network to enhance visibility and control. • Risk-Based Preventive Planned Maintenance (PPM) schedule implemented prioritising high-risk equipment to improve safety and efficiency • Efficient Equipment Use: The Equipment Library loaned 2,367 devices Trust-wide, ensuring timely access to vital equipment and minimising care disruption. • Proactive Capital Planning: Developed a 5-year capital replacement plan to forecast needs and reduce financial risk by systematically replacing aging or obsolete devices. • Digital Integration: Supported EPR implementation by ensuring equipment compatibility, enabling seamless data flow and improved patient care.

Plans for sustainability 2025/26:

- Continued EPR integration support to future-proof device connectivity and enhance digital transformation efforts across the Trust.
- Full RFID rollout by year-end to improve long-term asset tracking and operational efficiency.

2.1.9. Patient & Carer Experience (PACE) Programme

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Patient Experience	**Priority 3:** **Patient & Carer Experience (PACE) Programme** **Reason: Further improvements required to embed and sustain progress made.**	Excellent engagement and co-design following patient safety incidents	We acknowledge that while significant progress has been made in developing our PSIRF engagement processes, we have not achieved our ambition to fully demonstrate measurable impact from these initiatives over the past 12 months. Our analysis reveals that although we have successfully established co-design processes with families and staff for Patient Safety Incident Investigations, implemented focus groups with appropriate support mechanisms, and facilitated Board-level story sharing, we require enhanced data collection to evidence the effectiveness of these approaches. We have identified gaps in quantitative metrics, engagement satisfaction measures, and outcome tracking that would typically demonstrate comprehensive stakeholder involvement and improvement impact.	
		Responsiveness to complaints- driving improvements across key themes: We acknowledge limited progress against our complaint responsiveness targets over the past 12 months. However, this period has provided valuable insights into implementation challenges, enabling us to identify specific opportunities for improvement. Our analysis confirms that while our complaint resolution framework is robust, consistent execution across all organisational levels requires strengthening. We have identified key areas where enhanced coordination and adherence to established timelines between clinical areas, divisional teams, and central complaints functions will significantly improve our responsiveness.		

Priorities for 2025/26:

Engagement and Co- design following patient safety incidents

- Establish comprehensive measurement frameworks for PSIRF engagement by March 2026, including real-time feedback systems, satisfaction metrics from involved parties, and demonstrable evidence of improvements implemented through co-design processes

Complaints Responsiveness

- Strengthen Divisional Accountability and Escalation (Achieve 85% of complaints resolved within agreed timescales by March 2026 through enhanced divisional accountability and improved first-time response quality)
- Enhance Response Quality and Coordination: (Achieve 90% first-time comprehensive complaint responses by March 2026 through strengthened divisional-central team coordination and improved communication pathways).

2.1.10. Good governance compliance framework

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Well Led	**Priority 4:** Good governance compliance framework Reason: Part of our quality goals within the Trust's quality strategy- valuing the basics and keeping our patients safe (2019-2024)	Staff survey • Staff engagement & morale • People Promise implementation • Equality, Diversity and Inclusion (EDI)	• >50% staff survey response rate • Improved National Staff Survey scores across People Promise elements • National ranking for improvement in survey results	• Nationally recognised as 4th most improved Trust • Detailed scores for all seven People Promise elements • Overall Staff Engagement score improved from 6.80 to 6.89 • Morale score improved from 5.78 to 5.93 • 50.4% staff survey completion rate
		Embedding Risk Management Strategy	• Review number of open risks • Percentage of risks in approved stage review • Compliance with standardised 5x4 risk scoring metrics (ISO standards) • Commissioned external validation of risk management approach	• Demonstrated risk reduction by 14% from 532 in April 2024 to 459 in March 2025, demonstrating more sustainable approach. • Improved risk triangulation with incidents and patient feedback • Established clear risk escalation pathway from divisional level to Risk Management Group for high-rated risks

Plans for sustainability 2025/26:

Staff survey

- We will give continued focus on 'Voice that counts' theme with additional focus on developing Reward and Recognition initiatives
- We will reduce discrimination through EDI strategy and training and share narratives from FTSU Champions.

Risk Management

- We will develop formal e-learning digital risk management training programme
- We will expand the risk register functionality in our electronic system- Enhance
- We will continue to iteratively improve cross cutting narrative between Corporate Risk management priorities and Board Assurance Framework
- We will continue to embed & further develop cross-referencing between risks, incidents & patient feedback on our digital platform

2.1.11. Quality Assurance framework and Freedom to Speak Up

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Well Led	**Priority 4:** Good governance compliance framework	Quality assurance framework – standardised across new operational management model	Since the launch of our Quality Strategy in 2019, & Quality Governance Standard Framework in 2023/244 we have made significant strides in embedding a whole-system approach to quality—framing our work across planning, assurance, and improvement. Success has been measured through • enhanced oversight of clinical risk, • increased reliability of care processes, • strengthened patient and carer engagement, and • improved staff capability in delivering safe, effective services.	• Delivered on Patient Safety Incident Response Framework (PSIRF), co-designed with patients and carers, enabling a more compassionate, learning-oriented response to harm. • Established a comprehensive Quality Governance Standards Oversight Framework with clear lines of accountability at both divisional and system levels • Scaling of in-situ simulation training to support early recognition and management of deteriorating patients and sepsis. • Implementation of the Gold Standards Framework to enhance quality and consistency of end-of-life care • Development and roll-out of 'ENHance', a trust-wide digital platform that improves data access, quality oversight, and real-time decision-making
		Freedom to speak up- strengthening the FTSU MDT network	• Increased number of staff speaking up to raise concerns • Percentage of staff completing Speak Up training • Percentage of managers completing Listen Up training • Number and distribution of Speak Up Champions across staff groups • Staff survey responses regarding confidence in the speak up process • Reduction in anonymous concerns/whistleblowing	• Increased speaking up episodes to 311 in 2024/25- sustained year-on-year growth (from 190 in 2022/23 and 270 in 2023/24) • Enhanced service capacity with speaking up support accessible 5 days per week, including weekends • Achieved 87% completion rate for Speak Up training and 83% for managers' Listen Up training • Expanded FTSU Champion network to 40 representatives across all professional streams • Eliminated anonymous FTSU cases completely (0 in 2024/25)

Plans for sustainability 2025/26:

Quality assurance framework

- We will continue to ensure alignment with Trust strategic objectives and the Integrated Care System's transformation programmes.
- We will continue to embed Valuing the Basics and Good Governance principles as foundational to how care is delivered and monitored.
- We will continue to develop a learning health system, supported by digital innovation, patient safety partners, and a culture of continuous improvement
- We will continue to strengthen triangulation across patient experience, complaints, and incident data, particularly in post-incident support and carer involvement

Freedom to speak up

- We will continue to expand healthy teams action plan to promote psychological safety, with emphasis on compassionate accountability
- We will continue our collaborative work between FTSU Guardian, OD team and Governance to embed learning from Speak Up themes
- We will ensure protected time for Speak Up Champions to carry out their work
- We will ensure FTSU accessibility across all staff groups, with proportional representation from diverse ethnic backgrounds
- We will ensure Speak Up training completion for remaining 13% of staff and Listen Up training for remaining 17% of managers
- We will develop coaching for managers to enhance their ability to respond effectively to staff concerns.
- We will implement formal service level agreement between FTSU function and People Team with agreed timeframes for responses and actions
- We will integrate FTSU reports into Audit and Risk Committee and Quality and Safety Committee discussion

2.1.12. People strategy – Equality diversity and inclusion (EDI) actions

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Well Led	Good governance compliance framework	Clinical leadership programmes- nursing excellence faculty	Increase in education and development places	• 118 students across all programmes on site (excluding 100 UCL & 200 Cambridge medical students- yr 4-6) • 99 staff enrolled on the preceptorship programme • Preceptorship team shortlisted for Nursing Times Workforce Award • Staff satisfaction with flexible working improved from 6.17(2023) to 6.35 (2024), exceeding acute sector average of 6.24
		People strategy – Equality diversity and inclusion (EDI) actions		• Recruitment training on unconscious bias developed in 2024; to become mandatory in 2025/26 • EDI action plan workbook implemented • EDI Steering Group established to lead Trust-wide Inclusion work • Staff Network membership expanded with successful events including EID, Windrush Day & Pride participation

Plans for sustainability 2025/26:

- We will continue to address race discrimination and harassment
- Support staff disclosure of experiences with programmes in place to reduce harm from public and staff related incidents

2.2 Highlighted below are our 2025/26 priorities which are aligned with the Trust's objective priorities. These priorities were developed following appropriate consultation with relevant parties and presented to Trust Leaders

Quality Priorities 2025 to 2026			
Domain	**Quality Priority**	**Key Focus Areas**	**How We Measure Success**
Safe	**#Priority 1** Strengthening Fundamentals of Care & Governance (**All Divisions)**	• Daily incident huddles to support safety culture • Embedding of PSIRF processes at ward and site level • Governance standardisation • Closing the loop on learning from harm Safe staffing, core standards (NEWS2, escalation)	• Reduction in overdue incident closures • Compliance with core standards (NEWS2, Obs, escalation) • Staff feedback on basic care delivery
Well Led	**#Priority 2** Embedding a Learning Culture and PSIRF **(Planned, Unplanned & Cancer Services)** **(Trust-wide Governance)**	• Trust-wide PSIRF training and learning response adoption • Consistent incident response tools (e.g., Swarms, AARs) • Leadership visibility on safety themes and closures • Systematic use of governance tools and the Good Governance Matrix	• % learning responses completed using PSIRF tools • Audit compliance with learning closure loops • Safety culture metrics (staff survey, FTSU themes) • Standardised reporting across divisions
	#Priority 3 Embedding Leadership for Quality Improvement **(Trust-wide leadership and divisional QI leads)**	• Continued leadership development and ENHPS implementation • Divisional QI projects aligned to Trust priorities • Inclusive and resilient clinical engagement • Expansion of QI capability through coaching and training	• ENHPS adoption rates • Participation in QI training • Divisional QI initiatives linked to Trust goals • Clinical engagement metrics"

Domain	Quality Priority	Key Focus Areas	How We Measure Success
Effective	**#Priority 4** Quality-Driven Pathways Transformation (incl. Digital) **(Planned Care, Digital, Estates, Cancer)**	• Elective and emergency pathway redesign (same-day surgery, emergency theatre access) • Use of digital tools (OneEPR, remote MDTs) • Outpatient transformation and centralised booking • Estates improvements to streamline care delivery	• Improved waiting times & pathway efficiency (theatres, diagnostics) • Adoption of OneEPR functions • Increase in care closer to home (e.g. SACT)
Patient Experience	**#Priority 5** Person-Centred and Seamless Pathways **All divisions (esp. Women & Children's, Unplanned Care, Cancer)**	• Improved discharge coordination and continuity of care • Improving community paediatrics pathways of care • Establish effective seamless pathways in maternity - reducing delays in transfer of IOL's to delivery suite by 50% • MDT planning and personalised transitions • Reduction in readmission through seamless step-down care	• Discharge planning compliance • PALS/complaints themes on transitions • 50% reduction in transfer delays from IOL to delivery suite (baseline measurement required) • Percentage of IOLs transferred within target timeframe (e.g., <2 hours) • Percentage of referrals processed within agreed timeframes (baseline vs. target) • Pathway completion rates (children completing full care pathway) • Maternal satisfaction scores regarding transfer experience
	#Priority 6 Tackling Health Inequalities and Promoting Equity **(Women & Children's, Cancer, Trust-wide Strategy)**	• Targeted equity actions in maternity and paediatrics • NICU outreach and community transition models • Expanding access to cancer treatment closer to home • Use of local population data to prioritise access improvement'	• Reduction in access gaps (e.g. Paediatrics, NICU outreach • Development & triangulation of Local data on underserved populations • Patient engagement feedback loops

These quality priorities and other key quality indicators will be monitored regularly with oversight at various quality and patient safety forums. A quarterly report on progress against these priorities will be produced for the Trust Management Group and the Quality and Safety Committee.

2.3. Statements of Assurance from the Board

2.3.1. Review of services

The Trust continues to provide a range of acute and specialised services in 2024/25, including directly provided and sub-contracted services across four care divisions. The Trust has reviewed the data across all the relevant health services and operated in accordance with the NHS Operating Framework. For further details please refer to the Trust Annual Report.

2.3.2. Participation in clinical audits

East and North Hertfordshire NHS Trust (ENHT) continues to maintain a robust clinical audit programme, with ongoing reviews to ensure improvements in clinical practice, patient experience, and outcomes can be evidenced. In 2024/2025, the Trust was eligible to participate in 74 National Clinical Audit and Patient Outcomes Programmes (NCAPOP) and other national quality improvement initiatives, and actively engaged in 69 (93%) of those aligned with its services, following NHS England's guidance on prioritisation.

The Trust was ineligible for 26 national audits, primarily where specific services were not provided. This included several audits in Oral and Maxillofacial Surgery (oncology, trauma, reconstruction, and orthognathic surgery), cardiology and cardiovascular procedures (e.g., cardiac surgery, congenital heart disease, TAVI, LAAO, PFO closure), respiratory services (Pulmonary Rehabilitation, Pulmonary Hypertension), diabetes and obesity (National Obesity Audit, Diabetes Prevention Programme), and specialist surgery areas such as bariatric surgery and cleft services.
In mental health, the Trust did not participate in Prescribing Observatory for Mental Health (POMH) audits covering rapid tranquillisation, melatonin, and opioids, and was also ineligible for the National Clinical Audit of Psychosis and the Mental Health Clinical Outcome Review Programme. Participation was similarly not applicable to a range of paediatric and emergency audits, such as the Paediatric Intensive Care Audit Network and the Out-of-Hospital Cardiac Arrest Outcomes audit.

2.3.3. National Clinical Audit & Patient Outcomes Programme (NCAPOP) & NHS England prioritised national quality improvement programmes participation

The Trust's participation in NCAPOP and other prioritised national quality improvement programmes with completed data collection in 2024–2025 is summarised below, showing the number of cases submitted as a percentage of eligible cases.

Audit programme	Workstream	Participated?	Cases submitted	Case ascertainment
National Adult Diabetes Audit (NDA)	National gestational diabetes mellitus audit	Y	Data not available at time of reporting	
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Acute limb ischaemia	Y	7/7 clinical questionnaires & 1 organisational questionnaire	100%
Child Health Clinical Outcome Review Programme (NCEPOD)	Emergency paediatric surgery	Y	14/14 clinical questionnaires & 1 organisational questionnaire	100%
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Rehabilitation following critical illness	Y	6/6 clinical questionnaires & 1 organisational questionnaire	100%
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Blood sodium	Y	7/7 clinical questionnaires & 1 organisational questionnaire	100%
Child Health Clinical Outcome Review Programme (NCEPOD)	Juvenile idiopathic arthritis	Y	4/5 clinical questionnaires & 1 organisational questionnaire	80%
UK Renal Registry	Chronic Kidney Disease Audit	Y	Data not available at time of reporting	100%
UK Renal Registry	National Acute Kidney Injury Audit	Y	336	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)		Y	112	95.70%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme		Y	19	100%
National Comparative Audit of Blood Transfusion	Audit of NICE Quality standard QS138	Y	49	100%
National Comparative Audit of Blood Transfusion	Reaudit of Bedside Transfusion Practice	Y	14	140%
Sentinel Stroke National Audit Programme (SSNAP)		Y	883	>90%
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS):	Non-melanoma skin cancers	N		

Audit programme	Workstream	Participated?	Cases submitted	Case ascertainment
Perioperative Quality Improvement Programme (PQIP)		Y	169	Data not available at the time of reporting
National Vascular Registry (NVR)		Y	AAA repair 18 cases, carotid procedure 23 cases, lower limb bypass 23 cases, lower limb angioplasty 21 cases & lower limb amputation 18 cases	Data not available at the time of reporting
National Respiratory Audit Programme (NRAP)	Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Y	329	Data not available at the time of reporting
National Respiratory Audit Programme (NRAP)	Adult Asthma Secondary Care	Y	134	Data not available at the time of reporting
National Cancer Audit Collaborating Centre (NATCAN)	National Lung Cancer Audit (NLCA)	Y	211	100%
National Respiratory Audit Programme (NRAP)	Children & young people asthma in secondary care	Y	Data not available at time of reporting	
National Paediatric Diabetes Audit (NPDA)	Care and outcomes	Y	Data not available at time of reporting	
National Child Mortality Database (NCMD)	National Child Mortality Programme	Y	Data not available at time of reporting	
National clinical audit of seizures and epilepsies for children and young people (Epilepsy12)		Y	Data not available at time of reporting	
Perinatal Mortality Review Tool (PMRT)		Y	Data not available at time of reporting	
National Maternity and Perinatal Audit (NMPA)		Y	Data not available at time of reporting	
National Ophthalmology Database (NOD)	Age-related Macular Degeneration Audit	N		
National Ophthalmology Database (NOD)	Cataract Audit	N		
National Adult Diabetes Audit (NDA)	National Diabetes Core Audit	Y	Data not available at time of reporting	

Audit programme	Workstream	Participated?	Cases submitted	Case ascertainment
National Adult Diabetes Audit (NDA)	National Diabetes Footcare Audit (NDFA)	Y	230	100%
National Adult Diabetes Audit (NDA)	National Diabetes Inpatient Safety Audit (NDISA)	Y	Data not available at time of reporting	
National Adult Diabetes Audit (NDA)	National Pregnancy in Diabetes Audit (NPID)	Y	68	100%
National Adult Diabetes Audit (NDA)	Transition (Adolescents and Young Adults) and Young Type 2 Audit	Y	Data not available at time of reporting	
BAUS Data & Audit Programme	BAUS Penile Fracture Audit	Y	1	100%
BAUS Data & Audit Programme	BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Y	Data not available at time of reporting	
BAUS Data & Audit Programme	Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Y	Data not available at time of reporting	
National Cancer Audit Collaborating Centre (NATCAN)	National Kidney Cancer Audit (NKCA)	Y	Data not available at time of reporting	
National Cancer Audit Collaborating Centre (NATCAN)	National Prostate Cancer Audit (NPCA)	Y	Data not available at time of reporting	
National Cancer Audit Collaborating Centre (NATCAN)	National Ovarian Cancer Audit (NOCA)	Y	Data not available at time of reporting	
National Major Trauma Registry		Y	Data not available at time of reporting	
Royal College of Emergency Medicine (RCEM)- Emergency Medicine QIPs	Adolescent Mental Health	Y	Data not available at time of reporting	

Audit programme	Workstream	Participated?	Cases submitted	Case ascertainment
Royal College of Emergency Medicine (RCEM)- Emergency Medicine QIPs	Time Critical Medications	Y	Data not available at time of reporting	
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)		Y	Data not available at time of reporting	
Royal College of Emergency Medicine (RCEM)- Emergency Medicine QIPs	Care of Older People	Y	Data not available at time of reporting	
Royal College of Emergency Medicine (RCEM)- Emergency Medicine QIPs	Mental Health: self-harm	Y	Data not available at time of reporting	
National cardiac audit programme (NCAP)	National Heart Failure Audit (NHFA)	Y	Data not available at time of reporting	
National cardiac audit programme (NCAP)	Cardiac Rhythm Management (CRM)	Y	Data not available at time of reporting	
National cardiac audit programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Y	Data not available at time of reporting	
National Audit of Cardiac Rehabilitation		Y	2019	Data not available at the time of reporting
Intensive Care National Audit & Research Centre (ICNARC)	National Cardiac Arrest Audit (NCAA)	y	107	100%
Intensive Care National Audit & Research Centre (ICNARC)	Case Mix Programme (CMP)	Y	491	100%
National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Metastatic Breast Cancer (NAoMe	Y	Data not available at time of reporting	
National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Primary Breast Cancer (NAoPri)	Y	Data not available at time of reporting	
National Joint Registry (NJR)		Y	1050	98.50%
Falls & Fragility Fractures Audit Programme (FFFAP)	National hip fracture database (NHFD)	Y	420	99.10%
National Early Inflammatory Arthritis (NEIAA)		Y	138	100%
National Cancer Audit Collaborating Centre (NATCAN)	National Bowel Cancer Audit (NBOCA)	Y	Data not available at time of reporting	
British Hernia Society Registry		N		

Audit programme	Workstream	Participated?	Cases submitted	Case ascertainment
National Cancer Audit Collaborating Centre (NATCAN)	National oesophago-gastric cancer (NOGCA)	Y	Data not available at time of reporting	
National Cancer Audit Collaborating Centre (NATCAN)	National Pancreatic Cancer Audit (NPaCA)	Y	Data not available at time of reporting	
National Cancer Audit Collaborating Centre (NATCAN)	National Non-Hodgkin Lymphoma Audit (NNHLA)	Y	43	100%
National Audit of Dementia (NAD)		Y	Data not available at time of reporting	
Breast and Cosmetic Implant Registry (BCIR)		Y	25	
Learning disability and autism programme - Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)		Y	11	100%
Falls & Fragility Fractures Audit Programme (FFFAP)	National Audit of Inpatient Falls (NAIF)	Y	6	100%
National Audit of Care at the End of Life (NACEL)		Y	80	100%
National Emergency Laparotomy Audit (NELA)		Y	69	45%
National Emergency Laparotomy Audit (NELA)	No Laparotomy	Y	5	
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Confidential enquiries into maternal deaths	Y	Data not available at time of reporting	
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Perinatal Mortality Surveillance	Y	Data not available at time of reporting	
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Perinatal Mortality and Morbidity Confidential Enquiries	Y	Data not available at time of reporting	
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	National surveillance of maternal deaths	Y	Data not available at time of reporting	
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Confidential enquiries into maternal morbidity	Y	Data not available at time of reporting	

2.3.4. Reviewed National Clinical Audit and Patient Outcomes Programme (NCAPOP) reports

In 2024/2025, East and North Hertfordshire NHS Trust reviewed 15 National Clinical Audit and Patient Outcomes Programme (NCAPOP) reports, alongside a broader set of national audits across emergency care, critical care, stroke, maternity, and end-of-life services. The Trust achieved high compliance with national recommendations in most areas, demonstrating strong performance in most areas and a clear commitment to learning and continuous improvement**.** The Trust used insights gained to strengthen clinical quality, drive local service improvement, and ensure alignment with evidence-based practice.

Full compliance was achieved in audits covering oesophago-gastric cancer, lower limb amputation, neonatal care, infection control (2022–23), endometriosis, and cognitive assessments in older adults. These reflect strong multidisciplinary collaboration and quality oversight, with successes including faster cancer diagnosis times, robust COVID-19 symptom screening, and accurate pain and cognitive assessments in emergency care.
Where partial compliance was identified—such as in transitional care, end-of-life planning, sepsis management, stroke care, and perinatal mortality reviews—the Trust implemented targeted actions. These included introducing e-prescribing systems for timely antibiotic administration, enhancing stroke triage through AI and imaging protocols, developing personalised care plans, and strengthening perinatal governance through dedicated clinical leads and real-time action tracking.

Lessons learned across the audit reviews emphasised the need for improved isolation room capacity, earlier end-of-life conversations, and integrated mental health triage in EDs.
The Trust responded by enhancing pain assessment in fracture care, introducing shared access to mental health assessments, reviewing policies around mental health legislation, promoting shared clinical access to assessments, and embedding multidisciplinary planning.
Delays in critical care discharges, identified through ICNARC, are being addressed through longer-term discharge planning solutions and real time monitoring.
These audit-driven improvements have positively influenced service design, operational performance, and patient safety, supporting the Trust's ongoing commitment to evidence-based, person-centred care.

Nos	Audit Title	Compliance	Key Action/Learning	Status
1	NATCAN Oesophago-Gastric Cancer	100%	Improved clinician attendance and diagnosis coding	Completed
2	NCEPOD Lower Limb Amputation	100%	All recommendations met	Completed
3	NNAP Neonatal Intensive and Special Care	100%	All recommendations met	Completed
4	RCEM Cognitive Impairment in Older People	100%	All recommendations met	Completed
5	RCEM Infection Prevention (2022/23)	100%	Excellent COVID symptom screening	Completed
6	NCEPOD Endometriosis	100%	All recommendations met	Completed

Table 2: Summary of reviewed National Clinical Audit and Patient Outcomes Programme (NCAPOP) reports

2.3.5. Local clinical audits

Nos	Audit Title	Compliance	Key Action/Learning	Status
7	NCEPOD Cancer in Children, Teens and Young Adults	85%	Introduce e-prescribing and staff retraining for timely antibiotics in sepsis	In Progress
8	NCEPOD End of Life Care	83%	Implement GSF training and normalise palliative discussions	In Progress
9	RCEM Mental Health (Self-Harm)	83%	Develop triage process and mental health policy	In Progress
10	NCEPOD Transitional Care	75%	Ensure consistent use of personalised care plans	In Progress
11	NCEPOD Cancer in Children, Teens and Young Adults	75%	Improve isolation room availability	In Progress
12	Perinatal Mortality Review Tool	75%	Appointed leads, central action log, improved MDT oversight	In Progress
13	RCEM Fractured Neck of Femur	50%	Improve pain scoring and documentation	In Progress
14	SSNAP Stroke Care	50%	AI decision support, improve access to stroke unit and rehab	In Progress
15	ICNARC Critical Care (CMP)	Not rated	Address discharge delays; improve planning	In Progress

In 2024/25, East and North Hertfordshire NHS Trust carried out 110 local clinical audits across a wide range of specialties, reflecting a strong organisational commitment to quality improvement and evidence-based care. The audits covered clinical, diagnostic, and support services, with a focus on high-impact areas such as Obstetrics, Trauma and Orthopaedics, Cancer Services, Pharmacy, Emergency Medicine, and ENT & Audiology. Key themes included safe prescribing, guideline compliance, documentation standards, patient safety in complex clinical scenarios, and the effectiveness of multidisciplinary care pathways.

Many of these audits aligned with national priorities, including the Maternity Incentive Scheme, GIRFT, and the Ockenden recommendations. Outcomes from the audits supported targeted improvements such as enhanced obstetric documentation, safer antibiotic practices, and better adherence to imaging protocols.

	Project title & reference
Obstetrics	Venous thromboembolism in adults / reducing risk in hospital QS201: Antenatal and postnatal VTE management (24/25_Trust_Obstetrics_47)
OMFS	Tongue tie audit - An audit of the management of tongue-ties referred to the oral surgery outpatient setting. (23/24_ENT_2)
Executive SMT	Reaudit of Seven Day Hospital Services Self-Assessment Survey [Standards 2 (time to consultant review), 5 (diagnostics), 6 (interventions or key services) & 8 (ongoing review)] (24/25_Trust_ExecSMT_04)
Pharmacy	Reaudit of safe and secure storage of medicines (24-25_Pharmacy_02)
Dermatology	Re-audit of British Association of Dermatologists guidelines for biologic therapy for psoriasis 2020: a rapid update (24/25_Trust_Dermatology_04)
Diabetes and Endocrinology	Performance of Touch the Toes Test in renal wards for Diabetic Patients (24-25_Trust_Diabetes_05)
Trauma and Orthopaedics	Whether GIRFT National Suspected Cauda Equina Syndrome Pathway is followed by the referring clinicians while referring suspected acute cauda equina patients, taking into consideration the criterion of chronicity of symptoms (24-25_Trust_T&O_11)
Obstetrics	Reaudit of vaginal birth after caesarean section (23/24_Trust_Obstetrics_18)
Trauma and Orthopaedics	Use of Intraoperative Tourniquets Based on BOAST Guidelines (24/25_Trust_T&O_08)
General Surgery	Reaudit of the use of Gastrographic for management of ASBO (Re-audit of 18247) (23/24_Trust_GeneralSurgery_03)
Obstetrics	Risk assessment in labour (24-25_Trust_Obstetrics_62)
ENT & Audiology	RF ablation of thyroid nodules in accordance with NICE IPG562 (23/24_Trust_ENT_01)
ENT & Audiology	Referral pathway to audiology (24/25_ENT/Audiology_05)
ENT & Audiology	Rate of Post-thyroidectomy Infection, Hypocalcaemia, and Nerve Palsy (24/25_ENT/Audiology_04)
Emergency Medicine	QIP: Are chest radiographs conducted in accordance with British Thoracic Society recommendations for adults diagnosed with community acquired pneumonia (24/25_Trust_Emergency Med_02)
Obstetrics	Pulse Oximetry screening in Newborns (23/24_Trust_Obstetrics_19)
Obstetrics	Post-partum bladder care audit (inpatient & community (24/25_Trust_Obstetrics_05)
General Surgery	Post-operative hospital stays after appendectomy - why is it longer at Lister hospital (24/25_Trust_General Surgery_01)
Gastroenterology	Post Colonoscopy colorectal cancer (15540)
Obstetrics	Placenta praevia & accreta (24/25_Trust_Obstetrics_64)
Obstetrics	Perinatal mental health audit 2023 (24/25_Trust_Obstetrics_07)
Pharmacy	Outpatients prescribing of sodium valproate in under 55 years (men and women) according to the new NPSA alert released on 28th November 2023 (24-25_Pharmacy_06)

Acute Medicine	Outpatient pulmonary emboli management (24/25_Trust_Acute Medicine_03)
Gynaecology	Reaudit of the outpatient management of hyperemesis gravidarum (re-audit of 15575) (24/25_Trust_Gynaecology_01)
Trauma and Orthopaedics	Outcomes, Satisfaction & Reflection of Junior Doctor / Resident Doctor Rotation Induction (24-25_Trust_T&O_12)
Obstetrics	Operative Vaginal Delivery (unsuccessful instrumental births) (24/25_Trust_Obstetrics_46)
Pharmacy	Reaudit of omitted and delayed doses of critical medicine (24-25_Pharmacy_01)
ENT & Audiology	NHS national newborn hearing screening programme (24/25_ENT/Audiology_02)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP E - Assessment of patient dose and administered activity (24/25_Trust_MVCC_03)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP B.2 Practitioner audit (24/25_Trust_MVCC_04)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP B.3 Referral form audit (24/25_Trust_MVCC_05)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP.1 & EP1.3Consent, Communication of risk & benefit of radiation exposure & Enquiries of individuals to establish pregnancy and breastfeeding status: Pre-treatment (24/25_Trust_MVCC_06)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP.1 & EP1.3Consent, Communication of risk & benefit of radiation exposure & Enquiries of individuals to establish pregnancy and breastfeeding status: Treatment (24/25_Trust_MVCC_07)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP A Patient Identification Compliance Audit - treatment (24/25_Trust_MVCC_08)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP A Patient Identification Compliance Audit: Pre-treatment (24/25_Trust_MVCC_09)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP J - Clinical evaluation of radiation doses in Radiotherapy (24/25_Trust_MVCC_10)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP H – Written Information for Sealed Sources (24/25_Trust_MVCC_11)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: Non-medical exposures audit (24/25_Trust_MVCC_12)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP N IR(ME)R Procedure Comforters and Carers (24/25_Trust_MVCC_27)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: reaudit of EP K reduction of probability and magnitude of radiation incident (24/25_Trust_MVCC_15)
Radiology	MRI Foot and ankle: key clinical questions, leveraging iRefer (24/25_Trust_Radiology_03)
Plastic and Reconstructive Surgery	Metalwork MDT Review of Target Rate of Cases Discussed (24-25_Trust_Plastics_08)
Obstetrics	MEOWS / escalation audit - focus recovery care (24/25_Trust_Obstetrics_19)
Obstetrics	Maternity Incentive Scheme & Ockenden: Consultant attendance (at high risk/emergency cases) - Theme 3rd/4th degree tears (24/25_Trust_Obstetrics_11)

Obstetrics	Maternity Incentive Scheme & Ockenden: Reduced fetal movements in triage / Raising awareness of reduced fetal movements (MIS Element 3) (24/25_Trust_Obstetrics_12)
Obstetrics	Maternity documentation audit (2023-2024 attendances) (24/25_Trust_Obstetrics_04)
Obstetrics	Maternity Baby Friendly Standards Audit (24-25_Trust_Obstetrics_59)
Trauma and Orthopaedics	Management of children with acute musculoskeletal infection based on BOAST guidelines (24/25_Trust_T&O_06)
Safeguarding	Reaudit of Liberty Protection, Deprivation of Liberty (DOLs) & Mental Capacity Act (MCA) Audit (18499)
Pharmacy	Laxative prescribing on intensive care unit (24-25_Trust_Pharmacy_07)
Safeguarding	Reaudit of Laming (Child protection medical audit) (17922)
Radiology	Intravascular lithotripsy (IVL) for the treatment of calcified lesions in peripheral vascular disease Interventional Procedure (18310)
Stroke Medicine	Intracranial haemorrhage (ICH) (24_25_Trust_Stroke-03)
Obstetrics	HIV in Pregnancy: A 5-year review of the care of women at East and North Hertfordshire NHS Trust (24/25_Trust_Obstetrics_06)
Radiology	GP CXR pathway for suspected lung cancer (18734)
Executive SMT	GIRFT: Head trauma CT (24/25_Trust_ExecSMT_02)
Trauma and Orthopaedics	Follow up of lumbar discectomy patients in Lister Hospital (24-25_Trust_T&O_15)
OMFS	Follow Up Appointments in in Oral Surgery East and North Herts, How Long Is the Wait? (24/25_Trust_OMFS_02)
Plastic and Reconstructive Surgery	Reaudit of excision rates of BCC and SCC (23/24_Trust_Plastics_04)
Obstetrics	Evolution of IOL at ENHT (24/25_Trust_Obstetrics_03)
Gastroenterology	Endoscopic Ultrasound: Post-Clinical Effectiveness Committee approval (24/25_Trust_Gastroenterology_03)
Gastroenterology	Endoscopic Ultrasound: CEC conditional approval (23/24_Trust_Gastro_01)
Gastroenterology	Endoscopic full thickness resection (FTRD) using an over the scope clip (OTSC) in accordance with IPG580 (23/24_Trust_Gastro_02)
Trauma and Orthopaedics	Early Management of Paediatric Forearm Fractures Based on BOAST Guidelines (24/25_Trust_T&O_07)
Obstetrics	Duty of candour (24/25_Trust_Obstetrics_65)
Obstetrics	Diagnosis and management of early miscarriage (24/25_Trust_Obstetrics_01)
General Surgery	Delay in laparoscopic cholecystectomy in patients presenting with pancreatitis (24/25_Trust_General Surgery_02)
Obstetrics	Consultant presence at MOH (24-25_Trust_Obstetrics_61)

Emergency Medicine	Compliance with National Guidelines (RCR, BAUS) for Acute Renal Colic: Focus on CT-KUB Protocols and Analysis of Patient Wait Times (24/25_Trust_Emergency Med_03)
Gynaecology	Reaudit of complex endometriosis surgery audit - Domain 2 Enhancing the Quality of Life of people with long term conditions (24-25_Trust_Gynaecology_15)
Plastic and Reconstructive Surgery	Audit of complete excision rates of BCC and SCC (24/25_Trust_Plastics_02)
Gynaecology	Colposcopy: Patient Experience (24/25_Trust_Gynaecology_05)
Gastroenterology	Colorectal endoscopic submucosal dissection (ESD) in accordance with IPG335 (23/24_Trust_Gastro_03)
Cardiology	Clinical audit of the effectiveness of maximum fixed versus low escalating energy selection for direct current cardioversion of atrial fibrillation patients (23/24_Trust_Cardiology_02)
Dermatology	Clinical Audit against British Association of Dermatologists guidelines for biologic therapy for psoriasis 2020: a rapid update (24/25_Trust_Dermatology_01)
Dermatology	Clinical Audit against British Association of Dermatologists and British Photo dermatology Group guidelines for narrowband ultraviolet B phototherapy 2022 (24/25_Trust_Dermatology_03)
Stroke Medicine	Clerking of Patients Pre-Alerted as a Stroke at Lister Hospital (24_25_Trust_Stroke-02)
CH community	Children taking melatonin on East & North Hertfordshire community paediatricians' caseload; a prospective audit of numbers and associated workload (18292)
CH community	Reaudit of child protection medical audit 2022/2023. Safeguarding: Child Protection Audit of Standard Operating Procedures and review of 2019 Action Plan (24/25_Trust_CH Comm_01)
Pathology	Cervical biopsy and LLETZ Audit 2024 to look if all the core parameters for reporting are being followed (24-25_Trust_Pathology_01)
Obstetrics	Care in labour: 1st and 2nd stage labour observations and care (24-25_Trust_Obstetrics_61)
Diabetes and Endocrinology	Canagliflozin (10298)
Obstetrics	Caesarean birth NICE NG192 / QS 32 VBAC / Maternal request (24/25_Trust_Obstetrics_13)
Plastic and Reconstructive Surgery	Breast implant Audit (23/24_Trust_Plastics_01)
Obstetrics	Battle of the wrist bands: An Audit to assess wrist band use in Obstetric care (handwritten versus printed) (24-25_Trust _Obstetrics_63)
Trauma and Orthopaedics	Audit of post-operative inpatient care for orthopaedic patients undergoing joint replacement surgery of the lower limb. (23/24_Trust_T&O_3)
Ophthalmology	Audit of large macular holes. (23/24_Trust_Ophthalmology _1)
Critical Care	Audit of DNA CPR orders in General Intensive Care Unit (Lister Hospital) (17742)
ENT & Audiology	Audit of dictated letters from Lister ENT department (23/24_ENT_1)

Trauma and Orthopaedics	Audit of adherence to trust protocol for calibrated pelvic radiographs for elective total hip replacements at Lister Hospital (24/25_Trust_T&O_02)
Obstetrics	Reaudit of assessment of foetal growth GROW (24-25_Trust_Obstetrics_60)
ENT & Audiology	Antibiotics Guidance for Acute ENT Infections (24-25_ENT-Audiology_09)
Anaesthetics	Antibiotic prophylaxis in theatre (23-24_Anaesthetics_05)
Plastic and Reconstructive Surgery	Annual re-audit of SCC and BCC excision rates in the Plastic Surgery Department (24-25_Trust_Plastics_06)
Plastic and Reconstructive Surgery	Annual re-audit of outcomes of all free tissue flaps carried out by the plastic surgery department (24-25_Trust_Plastics_05)
Pharmacy	An Audit to Show Dexmedetomidine Prescribing Practice Compared Against our Critical Care Local Guideline (24-25_Trust_Pharmacy_08)
Child Health Acute	An Audit Report on Paediatric Registrar Review Clinic Referral and Outcome in a Secondary Care Hospital-Documentation Audit (24-25_Trust_CH Acute_02)
Oncology and Clinical Haematology	An audit of the management of Older Patients with early-stage lung cancer Radical radiotherapy for lung cancer in Older Patients (NICE Lung cancer: diagnosis and management, NG122 March 2024) (24-25_Trust_OCH_03)
Gynaecology	Abortion care QS199 including legal requirements (24/25_Trust_Gynaecology_10)
General Surgery	A&E referrals to General Surgery: Safe and Effective Emergency Care (24/25_Trust_General Surgery_03)
Child Health Neonates	A review of outcomes for babies placed on kaiser sepsis observations November 2023- March 2024 (23/24_CH Neonates_02)
Trauma and Orthopaedics	BPT guidelines Fragility hip and femur fracture (24-25_Trust_T&O_16)
Trauma and Orthopaedics	BOAST - Mobilisation and weightbearing after orthopaedic surgery– hip and lower limb (24-25_Trust_T&O_17)
Cancer Centre	PT4 – CT Simulation Breast July 2024 (24/25_Trust_MVCC_17)
Cancer Centre	PT 14- Head & Neck July 2024 (24/25_Trust_MVCC_18)
Emergency Medicine	Re-audit on the documentation of the neurovascular assessment in traumatic shoulder dislocation. (24-25_Trust_Emergency Med_05)
Stroke Medicine	Reaudit of the impact of MRI Scans on Stroke and Patient Flow (24-24_Trust_Stroke_05)
Cancer Centre	Real-world single centre experience of neoadjuvant nivolumab plus chemotherapy in respectable non-small cell lung cancer (24/25_Trust_MVCC_24)
Cancer Centre	Audit measuring quality of on call referrals in MVCC against the SBAR tool standard (24/25_Trust_MVCC_25)
Ophthalmology	Audit of surgical treatment of vitreomacular traction also known as VMT (24_25_Trust_Opthalmology-03)

2.3.6. Participation in Research

East and North Hertfordshire NHS Trust continues to place patients at the heart of its research efforts, with 3,151 patients recruited across 69 ethically approved research projects in 2023/24, spanning 15 clinical specialties. The Trust's top five recruiting studies ranged from cancer screening (BEST4, 2,071 participants) and dialysis care (RESOLVE) to perioperative outcomes, quality of life in cancer, and biomarker research for eosinophilic oesophagitis. These achievements were made possible by innovations such as mobile screening units and strong patient engagement.

The Trust's four-year research strategy aims to be recognised as an organisation where patients can meaningfully engage in and benefit from research. Objectives include aligning research with local needs, improving accessibility and inclusion, embedding research in service design, and leveraging data and digital tools responsibly. To better understand and improve the research experience, the Trust gathered feedback through a structured survey. The results are summarised in the table below.

Questions	2024/5 responses (total number = 132)
1. The information that I received prepared me for my experience on the study	92.1% Agree or Strongly Agree
2. I feel I have been kept updated about the research	72.0% Agree or Strongly Agree
3. I know how I will receive the results of the research	70.5% Yes or Yes to some extent
4. I know how to contact the research team if I have any questions or concerns	86.4% Yes or Yes to some extent
5. The researchers have valued my taking part in the research	87.1% Yes or Yes to some extent
6. Research staff have always treated me with courtesy and respect	94.7% Yes or Yes to some extent
7. I would consider taking part in research again	83.3% Yes or Yes to some extent

In 2024, Trust staff contributed 348 research publications, 35 of which were in collaboration with the University of Hertfordshire, showcasing a broad range of research in high-impact journals. Patient and public feedback remains central, with 132 survey responses in 2024/25 highlighting strong satisfaction with care, communication, and overall experience.

The monthly Patient and Public Involvement in Research Panel supports the design of locally relevant, patient-centred studies. Projects under review include digital therapies for tinnitus, AI in menopause care, outcome measures in end-of-life care, and inclusive communication tools in critical care for people with intellectual disabilities. This commitment to collaborative, inclusive research ensures that ENHT remains a forward-thinking organisation contributing to national and international health improvement.

2.3.7. Update on Commissioning for Quality and Innovation (CQUIN)

For 2024/25, the nationally mandated CQUIN scheme was paused, so there are no adjustments to reflect achievement of CQUIN metrics, although fixed payments should include the 1.25% funding previously identified for CQUIN.

2.3.8. Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC). It's current registration status is 'requires improvement'. The CQC did not take enforcement action against the Trust during 2024/25.

Following the 2023 CQC inspection, East and North Hertfordshire NHS Trust successfully submitted its action plan addressing all 'must' and 'should' requirements, with supporting evidence for 'should' actions submitted on 30 August 2024.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires Improvement ↑ Nov 2023	Requires Improvement ↓ Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023
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
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
Hertford County Hospital	Good Apr 2016	Not rated	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
Overall trust	Requires Improvement →← Nov 2023	Good →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023

The Maternity service at the Trust participated in the National Maternity improvement programme in inspection in 2023, following assessment from the national programme they successfully stepped down from this improvement program in 2024/25.

In the same year, the Trust participated in several regulatory reviews, including a Joint Targeted Area Inspection (JTAI) on safeguarding children, and additional quality assessments from the Environment Agency (waste management), NHS England (cervical screening), JAG (endoscopy services), and the ICB (SEND services).

Throughout the year, the Trust continued to strengthen its quality governance framework, embedding a culture of continuous improvement through revised reporting structures that support operational delivery. This work has been underpinned by a structured programme of internal and external mock inspections, quality assurance reviews, and well-led governance assessments. Additionally, the Trust expanded its Urgent Treatment services at the Lister site to further enhance patient access.

2.3.9. Reporting to Secondary Uses Service (SUS)

The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

During 2024/25, the Trust submitted data to the Secondary Uses Service for inclusion in Hospital Episode Statistics, all of which were included in the latest published dataset.

The percentage of records containing a valid NHS number was:

- 99.9% for admitted patient care (national average: 99.7%)
- 99.9% for outpatient care (national average: 99.7%)
- 99.5% for A&E care (national average: 98.2%)

The percentage of records with a valid General Medical Practice code was:

- 99.1% for admitted patient care (national average: 99.4%)
- 99.9% for outpatient care (national average: 99.4%)
- 100.0% for A&E care (national average: 99.2%)

2.3.10. Update on data quality

In 2024/25, the Data Quality Team focused on improving the quality of data captured in the Trust's patient administration system, Lorenzo, particularly around patient information, activity recording, and performance management. Accurate, valid, and timely data remains critical to the integrity of Trust reporting and supports decision-making across all areas of the organisation, ensuring services meet the needs of the local population.

For 2025/26, the team will review the Trust's Data Quality Strategy and Policy and continue to raise awareness of data quality issues through the monthly Data Quality Assurance Group and Data Alignment

Group. Key actions also include reviewing the data quality KPI dashboard to align with Trust objectives, developing a new Directory of Services covering all Trust sites, and supporting the implementation of the new Electronic Patient Record (EPR).

2.3.11. Update on Information Governance Toolkit (IGT)/ Data security

All health and care organisations are expected to implement the 10 National Data Guardian (NDG) standards for data security. These standards are designed to protect sensitive data, and to also protect critical services which may be affected by a disruption to critical IT systems (such as in the event of a cyber-attack).
The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that enables the Trust to measure their compliance against the NDG standards and demonstrate and that sensitive information is protected from unauthorised access, loss, damage and destruction.

The Trust remains vigilant in addressing rising data security threats affecting the health and care sector, including cyber-attacks, data breaches, and accidental losses.
In 2023/24, a dedicated Cyber and Information Governance function was established within the Chief Information Officer's directorate. This contributed to the Trust achieving "Standards Met" in its annual Data Security and Protection Toolkit (DSPT) submission for the first time since 2020/21.
In September 2024, the DSPT was aligned with the National Cyber Security Centre's Cyber Assessment Framework, significantly raising the level of assurance required. The Trust is preparing its 2024/25 submission against 232 new audit controls, aiming for a rating of "Partially Achieved." Between July 2024 and year-end, 39 incidents were reported via DSPT, with 5 meeting the threshold for reporting to the Information Commissioner's Office. The inclusion of personal data breaches logged in Enhance demonstrates strengthened awareness and compliance across the organisation.

2.3.12. Update on clinical coding

Data Security Standard 1, Personal and Confidential Data: The Trust conducts annual data quality audits to verify coded clinical data accuracy against patient records. Clinical coding validation is regularly performed for both admitted patient spells and outpatient attendances, with Admitted Patient Care (APC) audit results shown below:

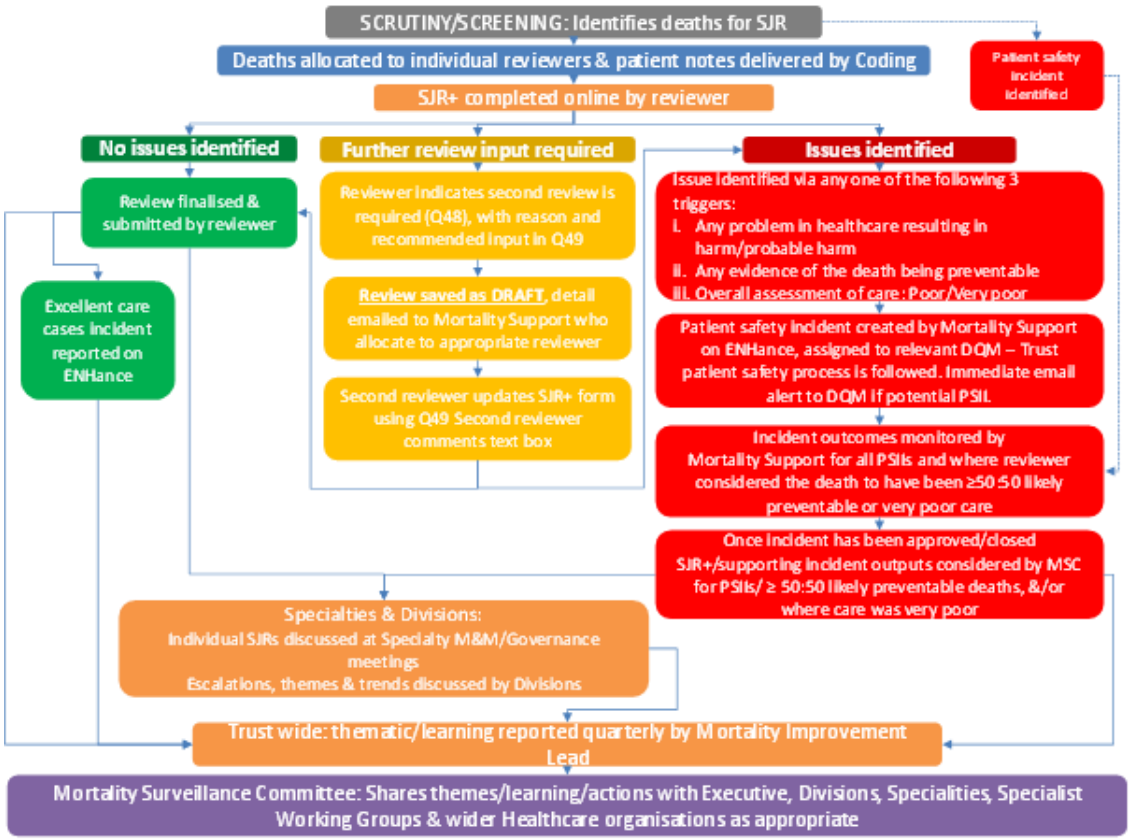
The Trust provides annual clinical coding training for all staff, with mandatory 3-yearly refresher courses completed by all. Two additional team members recently achieved the National Clinical Coding Qualification (NCCQ), with 4 more having sat the March 2025 exam, bringing our total Accredited Clinical Coders (ACC) to 11 staff members.

	2024/25	Previous year (2023/24)	Standards Exceeded
Primary diagnosis	95.5%	97.5%	>=95%
Secondary diagnosis	98.0%	97.0%	>=90%
Primary procedure	96.1%	97.1%	>=95%
Secondary procedure	98.0%	98.5%	>=90%

2.3.13. Update on learning from deaths

In 2024/25, East and North Hertfordshire NHS Trust continued to embed a strong learning from deaths process as part of its wider commitment to reducing avoidable mortality. The Trust uses the Structured Judgement Review Plus (SJRPlus) model, aligned with the *Better Tomorrow* framework (supported by Aqua and NHS England's *Making Data Count* approach).

Mortality governance is supported by clinical reviews, divisional governance, and thematic learning shared through mortality and morbidity meetings, safety forums, and working groups. While overall mortality rates remain within expected levels, the Trust recognises that mortality statistics alone do not reflect the quality of care and continues to focus on case-level learning and system improvement.



During the year, 1,395 deaths were recorded, of which 283 underwent case record review and 6 were investigated under the new Patient Safety Incident Response Framework (PSIRF). No cases were judged to be more likely than not due to problems in care, although 10 cases remain under active review (4 with preliminary findings suggesting preventability and 6 under PSII). Additionally, 74 retrospective reviews were completed from the prior year, with no preventable deaths identified.

Key themes identified from structured judgment reviews include delays in senior medical review, discharge planning, medication issues, and inconsistencies in end-of-life documentation (ReSPECT/TEP forms). Communication breakdowns during ward transfers, imaging delays, and inconsistent palliative care planning were also noted. These findings continue to inform targeted quality improvement efforts across the organisation.

The content and format of the learning from deaths information below has been provided in accordance with the statutory instrument 2017 No 744 ‘The National Health Service (Quality Accounts) (Amendment) Regulations 2017.

Statutory Ref	Prescribed information/indicator	2024/25 Summary	Additional Comments
27.1	Total deaths in 2024/25	1.395 deaths recorded. Q1: 315 Q2: 307 Q3:392 Q4:381	Deaths include those who died in ED and inpatient wards.
27.2	Case record reviews/investigations	283 reviews and 6 investigations Q1: 34 Q2:90 Q3:106 Q4: 59	In 0 cases a death was subjected to both a case record review and an investigation. Since adoption of the Patient Safety Incident Response Framework (PSIRF), investigation has been interpreted as referring to PSIIs
27.3	Deaths Judged more likely than not due to care problems	0% to date; 10 cases under active review	10 cases remain under review and may be reclassified in next year's report following further investigation under the Trust's SJRPlus and PSIRF processes.
27.4	Learning from reviews judged preventable	Pending	Investigations in progress
27.5	Actions taken as a result	Awaiting finalisation.	Investigations in progress
27.6	Impact of actions	Impact assessment pending implementation of actions	
27.7	Late reviews from 2023/24	72 case reviews 2 investigations	Relate to inpatient deaths which took place before the start of the reporting period.
27.8	Preventable deaths in late Reviews	0 deaths judged preventable	Estimated using the mortality review process methods detailed above in 27.3
27.9	Revised preventable deaths total for 2023/24	3 deaths (0.22%)	Represents revised total figures incorporating the sum of 27.3 from last year's report and 27.8 above.

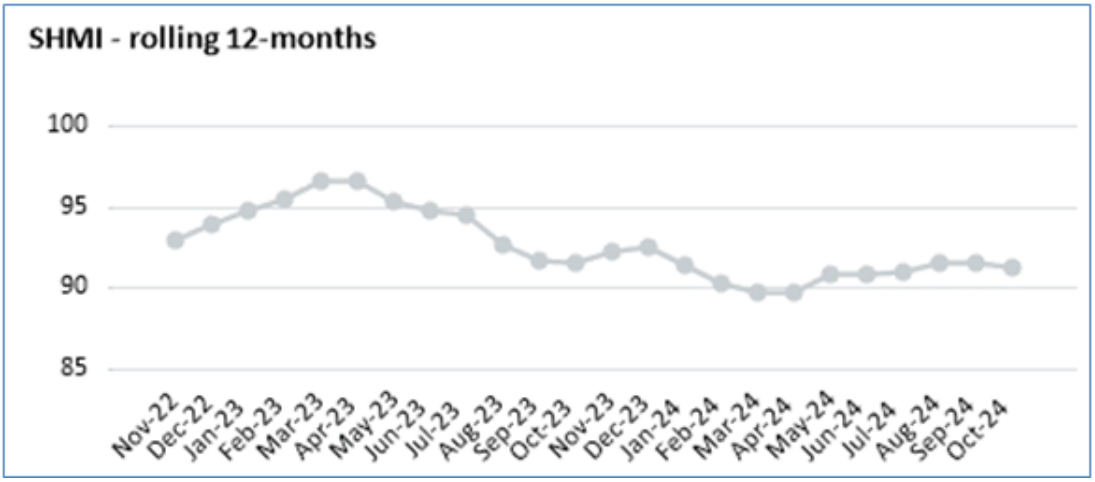
2.4. Performance against national core indicators

In this section the outcomes of a set of mandatory indicators are shown. This benchmarked data, provided in the tables, is the latest published on the NHS Digital website and is not necessarily the most recent data available. More up to date information, where available, is given.
For each indicator the Trust's performance is reported together with the national average and the performance of the best and worst performing trusts, where applicable.

2.4.1. Mortality

Performance against national core indicators

The Summary Hospital-level Mortality Indicator (SHMI) is expressed as a ratio of observed to expected deaths so that a number smaller than '1' represents a 'better than expected' outcome. The Trust's SHMI for the 12 months to November 2024 is 0.9015, positioned within the 'as expected' Band 2 category. SHMI is generally available five months in arrears.
The Trust's latest Summary Hospital-Level Mortality Indicator (SHMI) for the period December 2023 to November 2024 was 0.9015, within the 'as expected' range (Band 2), and ranked 19th out of 119 acute non-specialist trusts nationally.

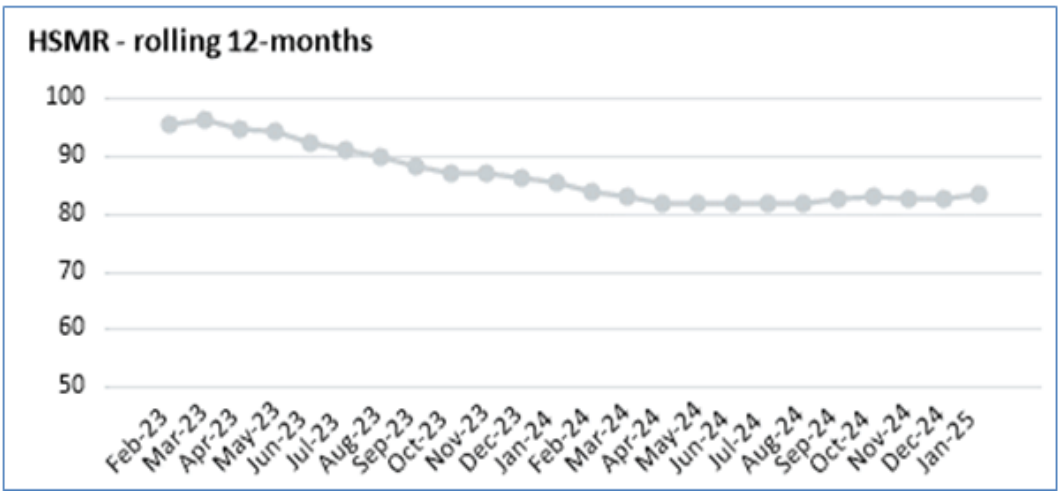


Rolling 12-month SHMI: November 2022 to October 2024

In the chart above, SHMI values are scaled by 100 for direct comparison with HSMR, where a value of 100 indicates observed deaths equal expected deaths.
SHMI values for each trust are published along with bandings indicating whether a trust's SHMI is '1 - higher than expected', '2 - as expected' or '3 - lower than expected'.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
SHMI	Value	0.9015	Dec-23 to Nov-24	0.9194*	0.7016	1.2849	1.0
	Banding	2		2	3	1	-
% deaths with palliative care coding	Percentage	41.0		44.0*	66.0	17.0	44.0

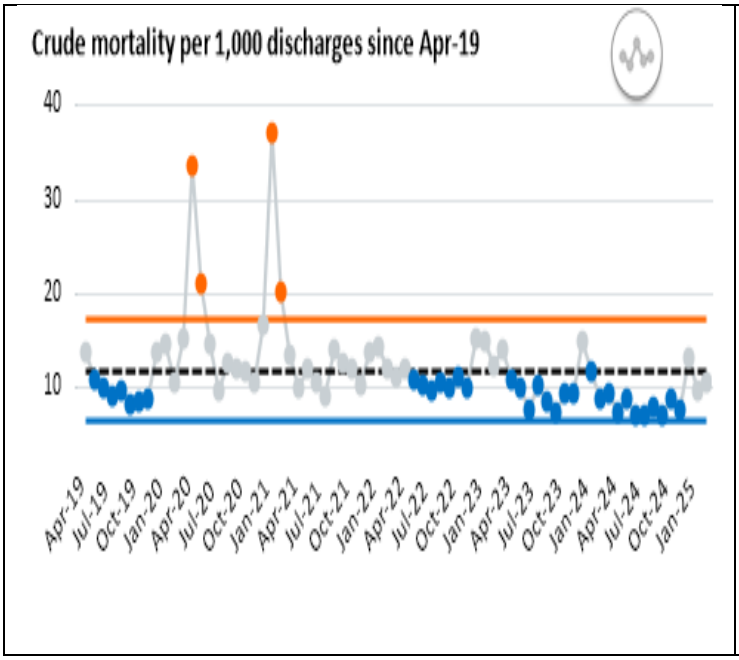
The Hospital Standardised Mortality Ratio (HSMR) for the year to January 2025 was 83.5, compared to a national average of 89.3. These results reflect sustained performance improvement supported by accurate clinical coding, timely reviews, and multidisciplinary learning processes.

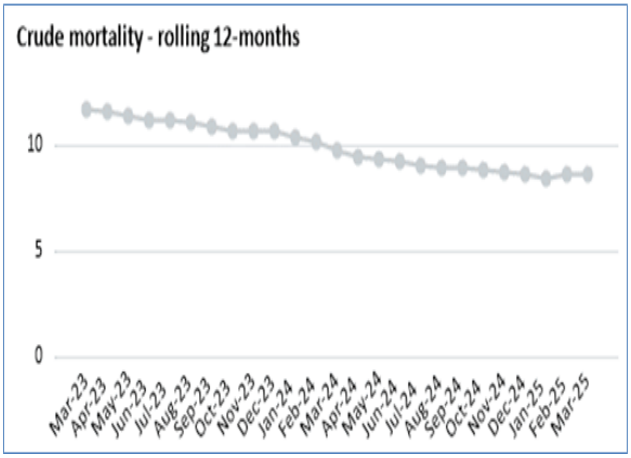


The Trust considers that this data is as described, as it is based on data submitted by the Trust to a national data collection and reviewed as part of the routine performance monitoring. The Trust has processes in place and takes on-going action to improve these scores, and consequently the quality of its services, including presenting and tracking monthly data to identify and investigate changes. The mortality data is also captured by diagnosis so any deviation can be investigated at a case-by-case level.

Crude mortality

Crude mortality also remained below national average for most of the year, with monthly monitoring and case-level diagnosis tracking used to identify variations and support responsive clinical governance. The Trust continues to use this data to refine local care delivery and prioritise safe, high-quality care for all patients**.**





2.4.2. Patient Reported Outcome Measures PROMs (EQ-5D Index Score)

PROMs use a standardised tool as a measure of health outcomes. It is applicable to a wide range of health conditions and treatments and provides a simple descriptive profile and a single index value for health status; the health gain index is primarily designed for self-completion by respondents and is ideally suited for use in postal surveys, in clinics and face-to-face interviews.
The Trust did not collect any data related to PROMs.

2.4.3. 30 Day/ Emergency readmissions

Readmissions data is only available until Jan 2024 and hence the data below is comparison of data from Apr - Jan period.

30 Day Readmissions	Apr 22 - Jan 23			Apr 23 - Jan 24			Apr 24 - Jan 25		
	0-15	16 & over	Total	0-15	16 and over	Total	0-15	16 and over	Total
Discharge	10533	86496	97029	8544	95657	104201	10369	111585	121954
30day readmissions	1317	4856	6173	894	5621	6515	1127	6824	7951
30day readmission rate 5	12.50%	5.61%	6.36%	10.46%	5.88%	6.25%	10.8%	6.12%	6.52%

*Data up to January 2025

We consider the above data as described because it is extracted directly from CHKS, which is an established and recognised source of data nationally.

2.4.4. The Friends and Family Test (responsiveness to patient needs)

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. This kind of feedback is vital in transforming NHS services and supporting patient choice.
Throughout 2024/25, we have maintained high performance in FFT scores across most areas. Positive feedback has remained consistent in our inpatient, outpatient, and maternity services. Areas for improvement have been identified through theme analysis from previous surveys, with targeted initiatives implemented in response. FFT data is submitted directly by patients and extracted from the NHS England national dataset.

The Trust considers that this data is as described for the following reason: the data has been extracted directly from the NHS England, which is an established and recognised source of data nationally.

Service Area	2022/23	2023/24	2024/25
Inpatient	96.3%	96.45%	96.34%
Outpatient	96.09%	96.34%	96.40%
Maternity	96.25%	98.17%	97.28%
Emergency Department	88.10%	92.61%	83.87%

*data as at March 2024. At the time of writing no figures have been released by NHS England.

As of March 2024, FFT response rates for A&E and inpatient services were 0.48% and 18.19% respectively. NHS England data for 2024/25 has not yet been released at the time of reporting.

2.4.5. Venous Thromboembolism (VTE)

VTE, which includes deep vein thrombosis and pulmonary embolism, remains a key patient safety focus. Since the launch of the Trust's Venous Thromboembolism (VTE) quality improvement programme in July 2021, significant progress has been made in prevention, governance, and clinical engagement.

Since October 2024, the Trust has adopted the NHS England standard requiring VTE risk assessments, prescribing, and prophylaxis to be completed within 14 hours of admission. This led to an initial compliance drop to 51%, now improving steadily to 63% by March 2025, with Low Molecular Weight Heparin (LMWH) prescribing maintained above 88%.

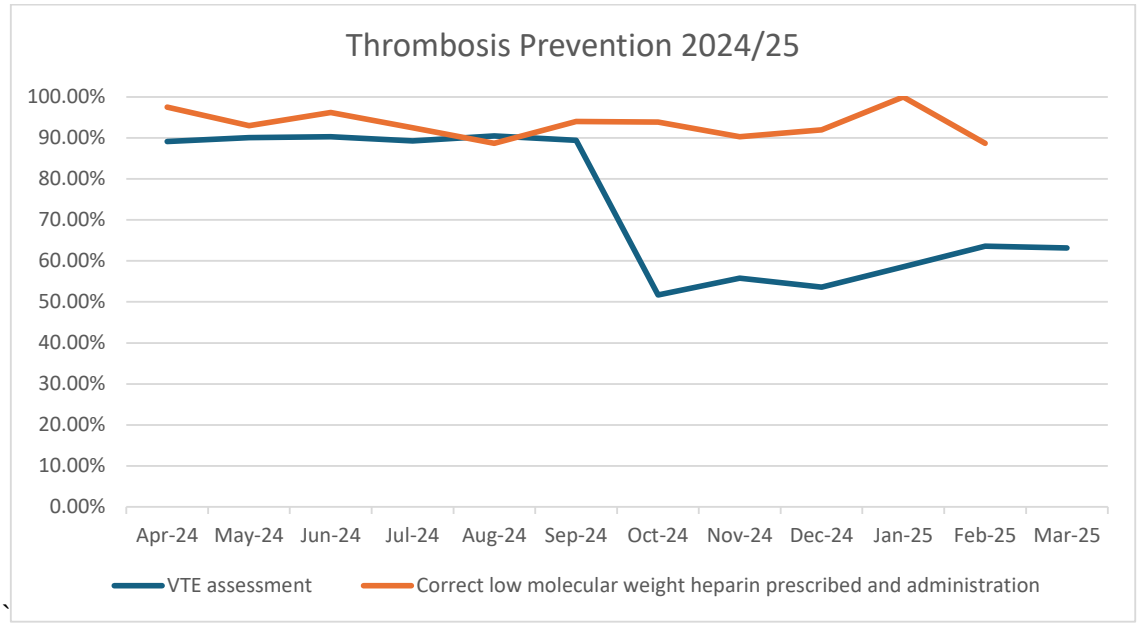


Figure 1: Audit data of clinical area's compliance with VTE prevention 2023/2024.

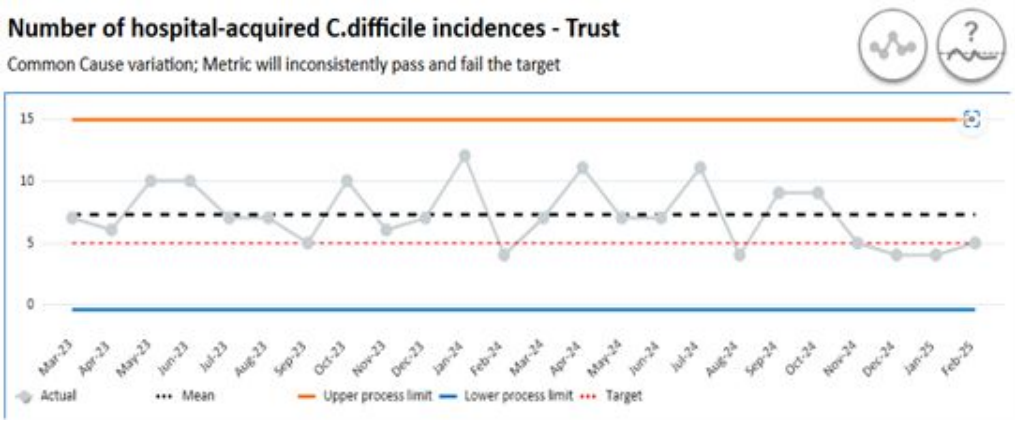
The Trust continues to investigate all potential Hospital Acquired Thrombosis (HAT) cases, with 8 preventable HATs identified in 2024/25—one declared a Patient Safety Incident Investigation (PSII) and reviewed under PSIRF.

The Trust has strengthened its VTE/HAT governance, introduced real-time digital dashboards, and embedded training and VTE standards into ward accreditation. Learning is shared through the Thrombosis Action Group, and patient information has been enhanced via digital discharge updates.

Priorities for 2025/26 include expanding the VTE improvement work to Emergency and Planned Admission pathways, redesigning the Thrombosis Action Group, and appointing a pharmacist to lead ongoing improvement initiatives. National benchmarking resumed in April 2024, with the first submission scheduled for July.

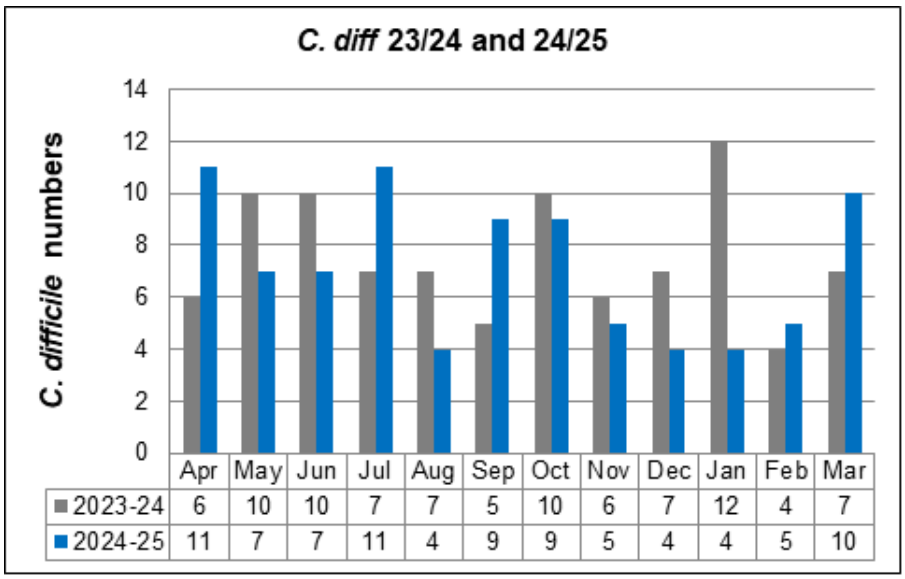
2.4.6. Clostridioides Difficile (CD)

In 2024/25, the Trust reported 86 cases of C. difficile, a 6.5% reduction compared to the previous year and within the threshold of 92. A multidisciplinary action plan and weekly C. diff review meetings supported this improvement, with 99% of cases found to be clinically unavoidable. Antimicrobial stewardship also improved significantly, particularly in timely review and appropriate use of antibiotics.



The Trust recorded two MRSA bloodstream infections, matching the 2023/24 total. Both cases were investigated through post-infection reviews, with learning actions implemented. E. coli bloodstream infections reduced by 9%, with most other gram-negative infection rates remaining within or just above thresholds. The

IPC team continued internal PIRs for all healthcare-associated infections and collaborated with specialist teams to strengthen ANTT and PIVC competencies.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24	6	10	10	7	7	5	10	6	7	12	4	7
2024-25	11	7	7	11	4	9	9	5	4	4	5	10

IPC training compliance increased from 93% to 98% across Level 1 and 2, reflecting sustained investment in workforce education. Key IPC highlights included the launch of the Trust-wide Winter Ready Campaign, an improved Power BI IPC dashboard, and enhanced training in high consequence infectious disease (HCID) pathways and aseptic technique. The Trust also maintained an active IPC engagement programme, with over 500 staff involved across audits, themed days, and targeted campaigns.

2.4.7. Patient safety incidents

In 2024/25, the Trust fully embedded the Patient Safety Incident Response Framework (PSIRF), marking a cultural shift from classifying incidents by harm level to proportionate, systems-based responses. The Trust's revised PSIRF policy and response plan, shaped by our inaugural year of implementation, was approved by the Patient Safety Forum and is being presented to Trust Board in July 2025.

Learning responses targeted key areas such as escalation of deteriorating patients, drug administration errors, discharge safety, and waiting list risks. The Learning from Patient Safety Events (LFPSE) system supported both incident and good care reporting, reinforcing a culture of transparency and continuous learning.

Incident reporting rose significantly, with 17,195 incidents reported in 2024/25, a 25% increase from 13,767 the year before and reflecting staff engagement in safety and transparency.

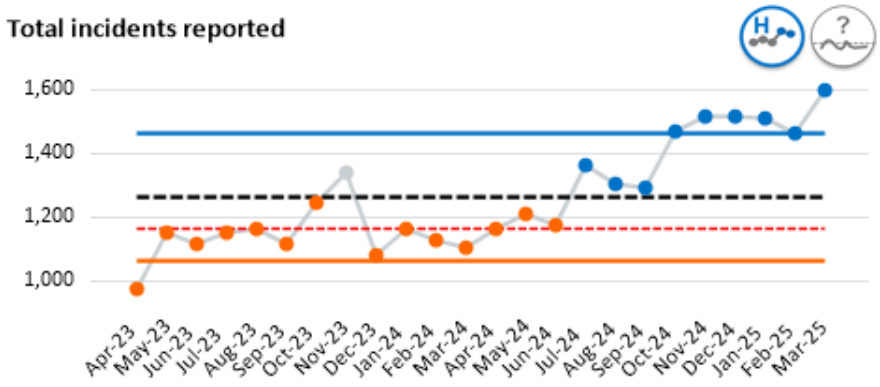
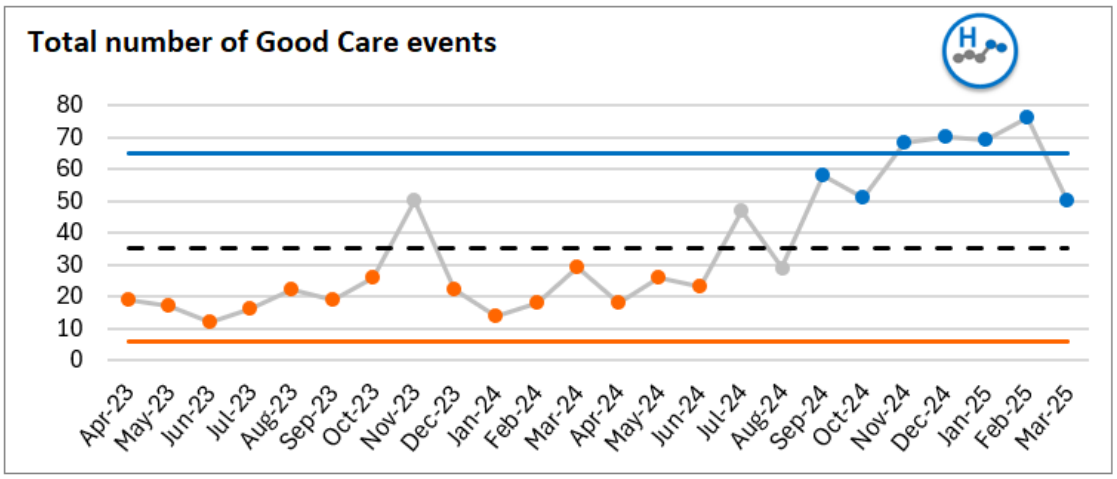


Figure 1: Total incidents reported – showing increased reporting year-on-year

Of these, 97% caused no or minimal harm, with 83% relating to patients and 11% to staff. The Trust continues to promote the reporting of good care events, with nearly 2,000 cases recognised, although this remains an area for further cultural embedding.



Top themes for patient safety included pressure ulcers, medication errors, obstetrics, and treatment concerns. For staff-related reported incidents, top themes included violence and aggression, staffing, security, and communication.

Patient Safety Incident Investigations (PSII) and Serious Incidents (SI)

Under PSIRF, 12 Patient Safety Incident Investigations (PSIIs) were undertaken, including events involving Never Events, safeguarding concerns, potentially avoidable deaths, and clinical errors. All investigations were initiated in response to incidents that met local or national PSII criteria, and each followed systems-based methodologies to understand root causes and prevent recurrence.

Themes included surgical safety (e.g., wrong site procedures, retained items), anticoagulation management, anaphylaxis, safeguarding, emergency care, and mental health-related incidents. Two investigations were externally led by the Maternity and Newborn Safety Investigations (MNSI) programme.

All cases were reviewed by the Patient Safety Event Response Panel, and learning disseminated through divisional governance structures, clinical education sessions, and thematic safety campaigns. Actions have included updates to invasive procedure documentation, strengthened clinical sign-off protocols, and improved oversight through the Trust's Invasive Procedure Oversight Group.

A legacy Serious Incident investigation continued throughout 2024/25 relating to the Trust's Paediatric Audiology Services, following a 2023 national peer review of the Neonatal Hearing Screening Programme. The review raised concerns regarding data quality, risk identification, and follow-up pathways, prompting the Trust to pause elements of the service due to potential patient harm. An improvement committee chaired by the Chief Nurse was established, supported by Integrated Care Board (ICB) partners and subject matter experts from Guy's and St Thomas' NHS Foundation Trust. The Trust also invited UKAS to undertake an external audit, which identified multiple safety concerns. While mutual aid pathways were implemented, access remained limited due to national capacity constraints.

The Trust's improvement plan focuses on six key domains: quality and safety, environment and equipment, digital systems, operational flow, workforce, and communication, with oversight by the Quality and Safety Committee. The full investigation report is scheduled for completion and sign-off in May 2025.

Never Events

The Trust reported five Never Events across different specialities, including wrong site surgery (2 cases), a retained surgical swab, incorrect prosthesis, and a misplaced nasogastric tube. A thematic review of the surgical events highlighted key contributory factors, including variation in safety check processes, time pressures, inconsistent whiteboard use and labelling, and inexperienced or unfamiliar theatre teams.

In response, the Trust has updated safety documentation, enhanced staff training, and introduced 7-day pre-operative list sign-off to reduce errors linked to pooled theatre lists. An Invasive Procedure Oversight Group has been established to lead on standardisation and cross-speciality learning, supported by the development of a central LocSSIP library on ENHance.

2.5. Other Quality Information

Operational performance appraisal summary- Emergency Department (ED) performance

The Trust managed high demand with 184,926 ED attendances, 52,012 inpatients, and 610,180 outpatient appointments. Industrial action impacted elective care, but key targets such as eliminating 104-week waits (except community paediatrics) and improving 78-week wait compliance were largely met. Trauma and orthopaedics remain an outlier, with improvement plans in place.

The Trust's focus throughout 2024/25 has been on improving urgent and elective care performance, reducing waiting times, sustaining strong cancer outcomes, delivering financial stability, and addressing diagnostic and stroke service improvements to enhance patient care and system resilience.

- The Trust prioritised improving emergency care and reducing ED waiting times, making significant capacity investments to support patient flow and ambulance handovers. Parallel efforts expanded elective capacity, resulting in higher levels of day-case, inpatient, and outpatient activity compared to the previous year, with further improvements planned for 2025/26.
- Diagnostic turnaround times remain a challenge, though capacity and demand modelling indicate DM01 compliance (except MRI) by March 2025. Community Diagnostic Centres (CDC) largely met targets, except cardiology due to GP uptake and workforce issues. Stroke care performance improved, with the Trust now rated 'B' and aiming for an 'A' rating through continued focused efforts.
- Cancer care remained a strong focus, with the Trust sustaining 75% compliance against the faster diagnosis standard. Collaborative efforts continue to address 62-day wait breaches, and the Trust's early adopter role in pathway analyser work has been nationally recognised.
- Incremental progress was made towards the four-hour ED target, achieving 73.18% (a 10% improvement year-on-year) despite increased demand. Ambulance handover times saw notable improvements through SDEC expansion, UTC development, and strengthened system collaboration, reaching 66.1% compliance for handovers within 30 minutes.

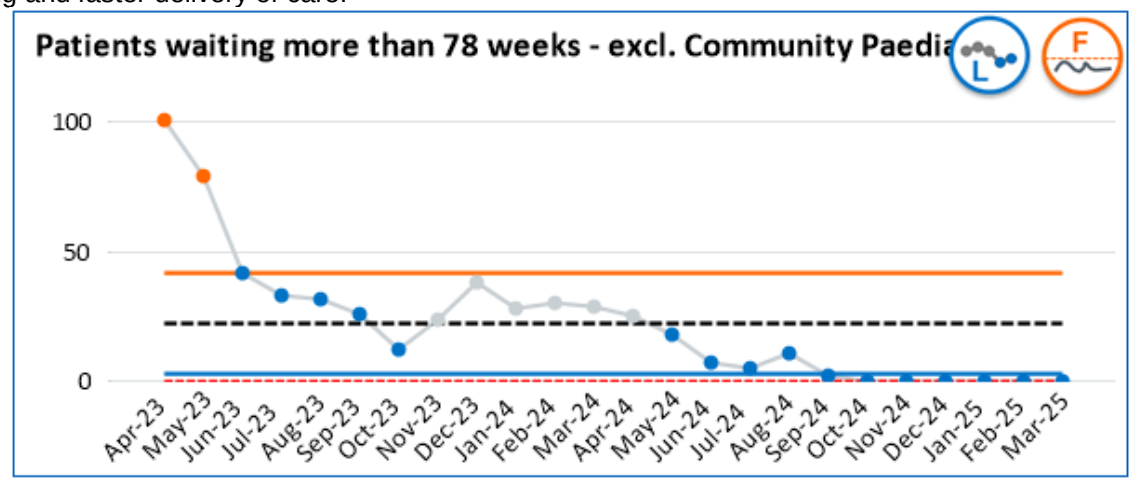
2.5.1. Performance Analysis: In-depth performance review

Operational Performance

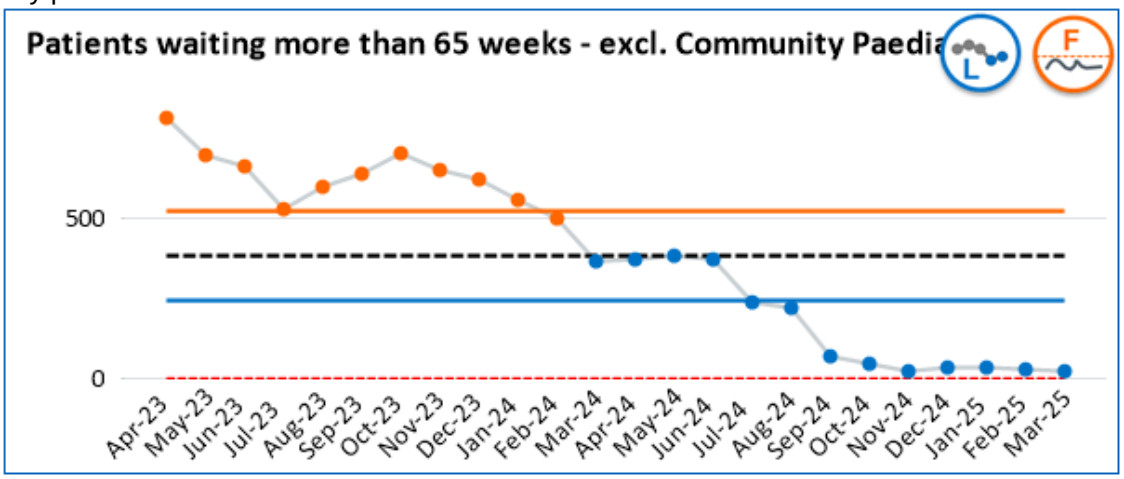
A summary of performance against the key metrics is provided below:

Referral To Treatment (RTT)

In line with national efforts to eliminate waits over 65 weeks and progress toward the 18-week referral-to-treatment target, the Trust has made significant improvements in waiting times during 2024/25. This has been achieved through targeted recruitment, increased clinical sessions, improved validation, and outpatient and theatre transformation. The Trust also participated in the national GIRFT programme to support shared learning and faster delivery of care.

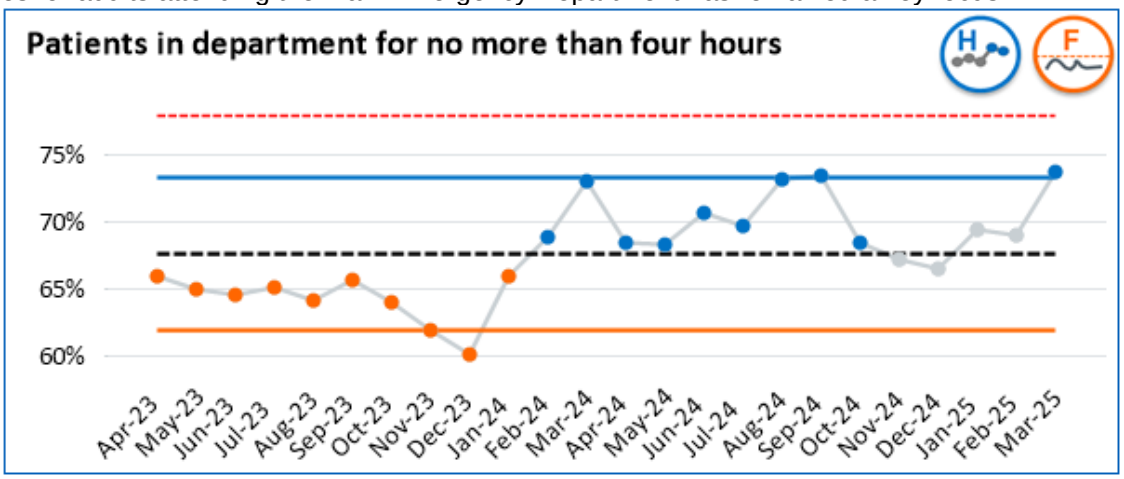


At year-end, only 26 patients (0.05% of the waiting list, excluding Community Paediatrics) were waiting over 65 weeks, with most services achieving the 52-week target. Exceptions included Trauma & Orthopaedics, Pain Management, Oral Surgery, and Urology. Proactive patient engagement efforts included over 114,000 text messages sent to validate patient willingness to wait, with 6.89% requesting removal from the list. The Trust continues to expand the use of Patient Initiated Follow-Up (PIFU) to improve flexibility and access for appropriate patients and is working with system partners to address longstanding capacity challenges in community paediatrics.

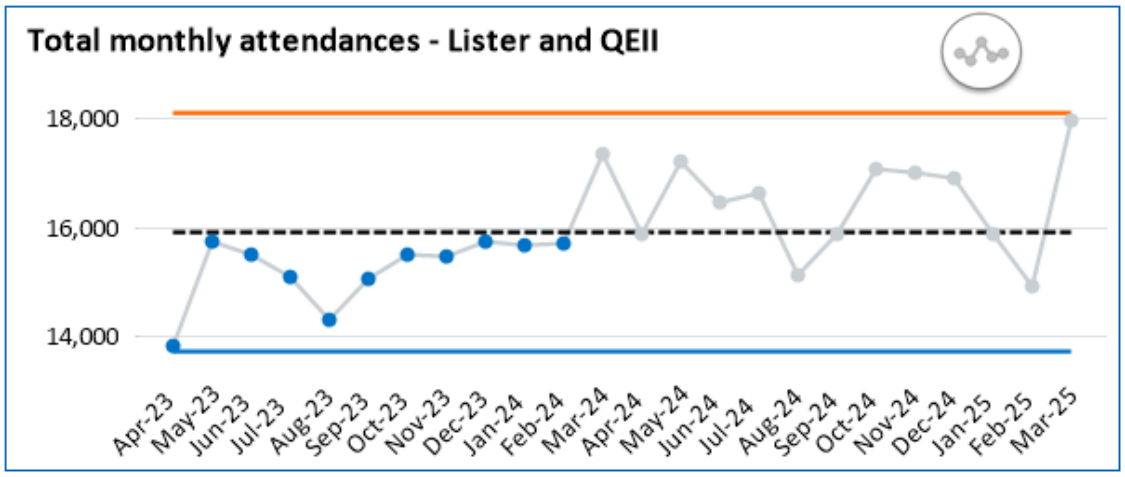


Urgent Care Pathways

In 2024/25, the Trust continued to work towards the national four-hour emergency care standard, which requires that 78% of patients attending ED or UTCs are admitted, transferred, or discharged within four hours. While performance in Urgent Treatment Centres and Children's ED remained consistently strong, improving outcomes for adults attending the main Emergency Department has remained a key focus.

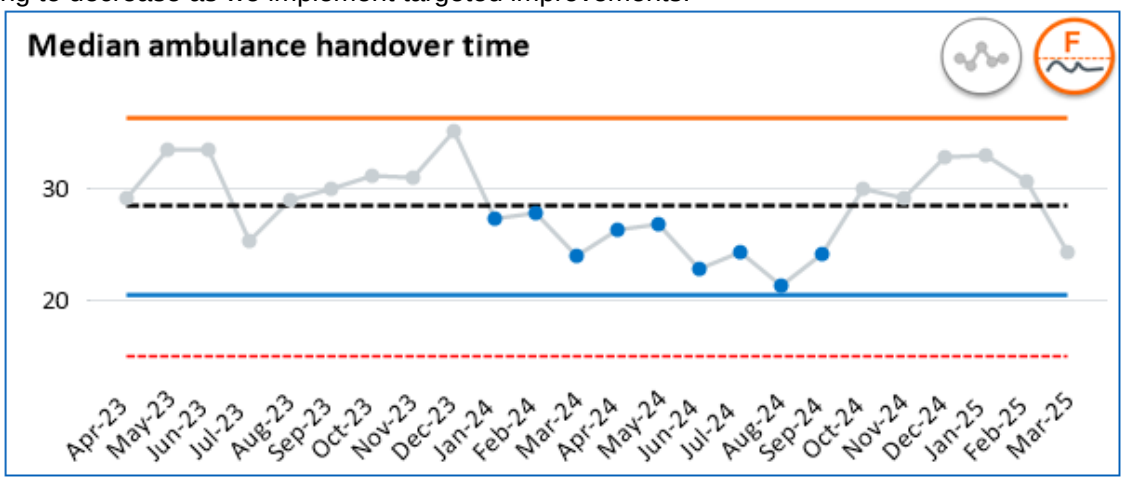


To address this, the Trust progressed a system-wide emergency care transformation programme aimed at reducing unnecessary ED attendances, improving flow, and enhancing patient experience. Key developments included the formal re-establishment of the Surgical Assessment Unit (SAU) and launch of the Surgical Same Day Emergency Care (SSDEC) service, both of which assess over 30 patients daily and now accept direct GP referrals. The Acute Medical Services (AMS) team will reset its service model from April 2025 to improve flow from ED and reduce inpatient admissions. Additionally, the Same Day Emergency Care (SDEC) service extended opening hours to 10pm to increase streaming capacity, and Children's ED improvements—such as an additional triage room and redesigned rosters—contributed to a measurable improvement in performance. By March 2025, Trust-wide four-hour performance had improved to 74%.



Ambulance handover

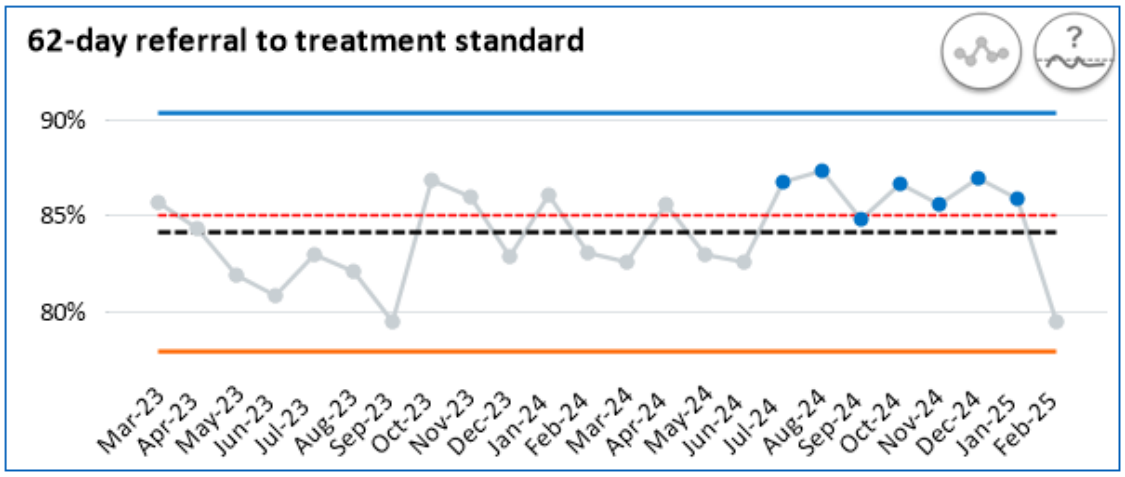
The Trust with East of England Ambulance Service Trust (EEAST) and other partners including Hertfordshire Community Trust, primary care, and other acute providers, worked hard to significantly reduce handover time for those patients brought to the department by ambulance. The target is 65% handover within 15 minutes. During the first nine months of the year, our ambulance handover times consistently remained under 30 minutes. However, as winter approached, we experienced an increase in patient acuity, leading to longer handover times. Despite these challenges, we are now observing a positive trend, with handover times beginning to decrease as we implement targeted improvements.



Cancer performance

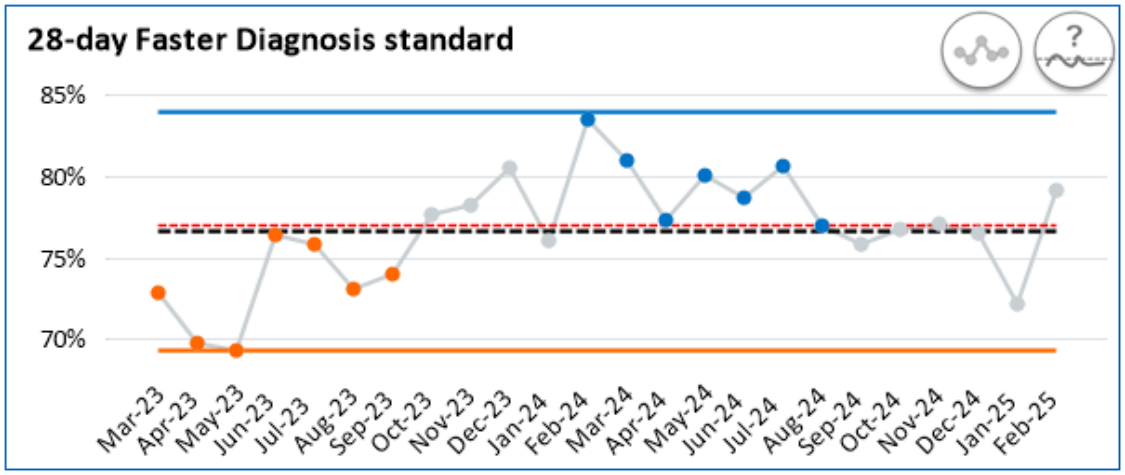
During 2024/25, the Trust reported on the three national cancer standards: the 28-day Faster Diagnosis, the 31-day Treatment, and the 62-day General standards.

The 62-day standard, while not consistently sustained, remained one of the strongest regionally and among the top ten performing trusts nationally. Challenges included increased two-week wait referrals, capacity constraints in imaging and endoscopy, and complex diagnostic pathways. Remedial actions are in place for 2025/26.



The 31-day treatment standard was maintained throughout the year, with one temporary dip due to radiotherapy capacity issues. These have been resolved through new linac machines and full staffing.

The 28-day Faster Diagnosis standard was consistently met, with performance reset to an 80% target by March 2026. The Trust's early adoption of the NHS England cancer pathway analyser tool has supported improvements and been nationally recognised.



Diagnostics: Standard: less than 1% of patients should wait 6 weeks or more for a diagnostic test
In diagnostics, while the Trust did not fully meet the national target of <1% of patients waiting over 6 weeks for a test, there has been a 43% reduction in >6-week waits and a 64% reduction in >13-week waits since April 2024. These improvements were driven by targeted capacity planning and productivity initiatives, despite increased demand from urgent and cancer referrals.

Stroke performance

The Trust maintained a B rating overall in the Sentinel Stroke National Audit Programme (SSNAP) since July 2023, with further ratings expected in mid-2025 following national methodology changes introduced in October 2024. Notably, confirmed stroke cases have exceeded the SSNAP monthly baseline of 63, with 91 confirmed cases reported in February 2025.

Significant progress was achieved across several domains. The Hyperacute Stroke Unit (HASU) was awarded an A rating, driven by improvements in rapid CT scanning under the new 'Straight to CT' pathway. The service also met its Trust-specific thrombolysis target of 14%, supported by a collaborative NHS England improvement programme. Future gains are expected from the introduction of CT Perfusion (CTP) in April 2025 and the full rollout of Stroke Video Triage, which has already shown benefit in speeding up pre-alert response.

Therapy services improved MDT input in 2024, though upcoming SSNAP changes will raise therapy frequency targets to three hours daily, likely impacting scores in the short term. Plans to mitigate this include establishing a new therapy gym and growing the speech and language therapy workforce through a development pipeline.

Challenges remain in timely admitting patients to the Stroke Unit within four hours and safeguarding dedicated stroke beds during periods of peak demand. The team aims to address these through pathway redesign, enhanced collaboration with other departments, and expanded out-of-hours and weekend medical cover.

The Trust continues to hold an A rating for case ascertainment, reflecting the consistent performance of the Stroke Data Team.

Seven Day Service

The national Seven Day Hospital Services (7DS) Programme is a quality improvement initiative providing acute provider organisations with a framework to work to reduce variation in outcomes for patients admitted to hospitals in an emergency and at the weekend across NHS trusts in England. There are four priority standards:

Standard 1: all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 14 hours of admission. An audit undertaken in 2023 identified that approximately 66% of patients were reviewed within 14 hours of admission by a consultant.
The table below details the schedule for on-site consultant cover for our acute specialities: -

Specialty	7-day Consultant on-site rota cover
Acute Medicine/General Internal Medicine	0800-2100
Anaesthetics	0800-1800
Critical Care	0800-1800
Emergency Department	0800-2200
General Surgery	0800-1800
Obstetrics	24-hour consultant cover on site: 08:30 to 17:00 Monday to Sunday
Paediatrics	0830-2100
Respiratory	0830-1730
Trauma and Orthopaedics	0800-1800

Standard 5: inpatients must have scheduled 7-day access to diagnostic services.
The table below details our compliance with standard 5 regarding access to these emergency diagnostic tests

Emergency diagnostic test	Available at weekends
USS	Yes
CT	Yes
MRI	Yes
Endoscopy	Yes
Echocardiography	Yes
Microbiology	Yes

Standard 6: inpatients must have timely 24-hour access to key consultant -directed interventions.
The table below shows compliance regarding access to emergency consultant-led interventions:

Emergency Intervention	Available on site at weekends	Available via network at weekends	Not available
Intensive Care	Yes		
Interventional radiology			Yes
Interventional endoscopy	Yes		

Emergency Intervention	Available on site at weekends	Available via network at weekends	Not available
Surgery	Yes		
Renal Replacement Therapy (RRT)*	Yes		
Radiotherapy		Yes	
Stroke Thrombolysis		Yes	
Stroke thrombectomy		Yes	
PCU for MI	Yes		
**Cardiac pacing			Yes**

*RRT is available 7 days a week 24 hours a day. This is for haemodialysis and is carried out by nursing staff with medical oversight in an emergency where access needs to be established, and the patient reviewed prior to commencing RRT.
**Cardiac pacing is not available on site at weekends on site. It is provided by the network if required.

Standard 8: patients with high dependency needs should be seen by a consultant twice daily; then daily once a clear plan of care is in place. An audit during 2023 identified that approximately 60% of a sample of patients were reviewed within 14 hours of admission.

Rota Gaps

As part of the annual review, all departments are required to assess resident doctor rotas to ensure they meet both service needs and the educational and contractual requirements for doctors in training. This process addresses rota gaps arising from staffing changes, with prompt recruitment efforts and a focus on improving role attractiveness and induction processes to expedite full rota participation.

In 2024/25, the Trust's new shared leadership structure across care groups further supported improved rota gap coverage and workforce resilience.

Staff/ National staff survey

For 2025/26, we will focus primarily on themes around the following and continue work in other areas:

- 'Voice that counts'
- Reward and Recognition

Our overall scores shown below indicate improvements in all categories:

People Promise elements	2023 score	2024 score	Statistically significant change?
We are compassionate and inclusive	7.13	7.22	Significantly Improved
We are recognised and rewarded	5.83	5.91	Not significant
We each have a voice that counts	6.56	6.65	Significantly Improved
We are safe and healthy	5.99	6.09	Significantly Improved
We are always learning	5.55	5.78	Significantly Improved
We work flexibly	6.17	6.34	Significantly Improved
We are a team	6.65	6.76	Significantly Improved
Themes			
Staff Engagement	6.80	6.89	Significantly Improved
Morale	5.78	5.93	Significantly Improved

The Trust 2024 staff survey results resulted in 50.4% of staff completing the survey and the returns showed as statistically valid. ENHT is nationally recognised as the 4th most improved trust in its survey results.
In 2025/26, the Trust will continue its focus under the theme **"A Voice That Counts,"** with particular emphasis on strengthening how staff concerns about unsafe clinical practice are captured, shared, and acted upon through the Freedom to Speak Up Champions. This work aims to ensure that raising concerns leads to tangible improvements in patient care.

The Trust will also build on its commitment to reducing discrimination from patients, service users, and between staff by advancing actions from the Equality, Diversity and Inclusion (EDI) strategy. This will be supported by the newly established EDI Steering Group, which will enhance organisational learning and assurance.
Ongoing efforts will include training in recognising bias, holding courageous conversations, and continuing programmes such as de-escalation and breakaway training to support an inclusive, respectful, and safe workplace.

Patient Experience

Complaints and Compliments

In 2024/25, the Trust received 904 formal complaints, an 18% increase from 763 in the previous year. Complaint's themes most commonly related to communication and medical care.
The Trust recorded 5,864 PALS enquiries, a 26% rise from 2023/24, with 53% resolved within five days. Encouragingly, 68% of formal complaints were responded to within an agreed timeframe, an improvement on 48% the previous year, though below the Trust's 80% target. A total of 503 compliments were received and shared with staff, divisional leads, and the Chief Executive, up from 295 the year prior.

Indicator	22/23	23/24	24/25
Number of formal complaints	746	763	904
Number of PALS concerns	3496	4657	5864
Number of PALS concerns closed within 5 days/ % performance	1951 55%	2508 54%	3116 53%
Complaints – response within agreed timeframe	50%	48%	68%

*The Trust KPI is 80% of formal complaints to be responded to within an agreed timeframe

Our Trust recognises that complaint responsiveness improvements have not met expectations over the past 12 months, requiring sustained focus to embed progress made. The PACE Programme targets enhanced service responsiveness, volunteer engagement, and carer support accessibility.
We delivered over 12,000 volunteer hours across 4,000+ shifts while recruiting 23 Carer Volunteers into key support roles. Trust-wide initiatives included carer concessions, information packs, dementia grab packs, and personalized care posters to better meet patient and carer needs.
To strengthen resolution and responsiveness, new divisional dashboards using RAG ratings have been introduced to track complaint stages. The Trust will launch targeted complaints and PALS eLearning for Band 5 staff and above, and continues to promote early, face-to-face resolution with families. A business case has been submitted to enhance PALS staffing capacity to meet growing demand.

Parliamentary and Health Service Ombudsman complaints

In the reporting year, fifteen re-opened complaints were assessed by the Parliamentary and Health Service Ombudsman (PHSO). Five complaints were closed with no further investigation, three were partially upheld with learning for the Trust and seven remain under investigation.

Freedom to Speak Up / Raise Concerns:

In 2024/25, 311 staff raised concerns through the Freedom to Speak Up (FTSU) service, continuing a year-on-year increase (190 in 2022/23 and 270 in 2023/24). This sustained rise reflects a growing culture of openness and psychological safety. In response to rising demand, the FTSU service expanded its availability to five days per week, including weekends. The service continues to support improvements in patient safety, staff experience, and organisational learning. Key achievements include 87% completion of Speak Up training and 83% completion of Listen Up training among managers.

Staff Group	Numbers
Additional Professional Scientific & Technical	2
Additional Clinical Services	5
Administrative & Clerical	10
Allied Health Professionals	4
Medical & Dental	6
Nursing & Midwifery Registered	13
Total	**40**

The Speak Up Champion network grew to 40 trained champions representing all staff groups and grades. Concerns raised spanned worker wellbeing (47%), inappropriate behaviours (35%), patient safety (12%), and bullying and harassment (6%). Notably, no anonymous FTSU cases were recorded, and there was a marked reduction in anonymous CQC whistleblowing concerns. The Trust also reported a 3% increase in staff survey responses indicating confidence that concerns would be addressed.

Who is Speaking Up: In the year 2024/25, all staff groups across all sites accessed Speaking Up Service. The table below provides further details:

Staff Group	Number of Concerns Raised	Percentage
Additional Professional Scientific & Technical	16	5%
Additional Clinical Services	29	9.5%
Administrative & Clerical	52	17%
Allied Health Professionals	34	11%
Estates & Ancillary	7	2.3%
Healthcare Scientists	15	5%
Medical & Dental	62	20%
Nursing & Midwifery Registered	89	29%
Students	6	1.9%
Unknown (anonymous)	0	0
Other	1	0.3%
Total	311	100%

The predominant themes raised through the FTSU service in 2024/25 were worker safety and wellbeing (47%), inappropriate behaviours and incivility (35%), and patient safety concerns (12%), with a smaller proportion relating to bullying and harassment (6%).

Key issues included workplace stress linked to office moves, breakdowns in staff-manager relationships, failure to follow key HR processes, perceived discrimination, and concerns over staffing levels, skill mix, and clinical standards. These themes continue to highlight the importance of strong people management, inclusive communication, and psychologically safe team cultures as enablers of both staff wellbeing and patient safety

Part 3: Other information

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Integrated Care Board (HWE ICB) response to the Quality Account of East and North Hertfordshire Teaching NHS Trust for 2024/2025.

NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) welcomes the opportunity to provide this statement on the East and North Hertfordshire Teaching NHS Trust (ENHTT) Quality Account for 2024/25. The ICB would like to thank ENHTT for preparing this Quality Account, developing future quality priorities, and acknowledging the importance of quality at a time when they continue to deliver services during ongoing challenging periods. We recognise the dedication, commitment and resilience of staff, and we would like to thank them for this.

HWE ICB is responsible for the commissioning of health services from ENHTT. During the year the ICB has been working closely with ENHTT in gaining assurance on the quality of care provided to ensure it is safe, effective, and delivers a positive patient experience. In line with the NHS (Quality Accounts) Regulations 2011 and the Amended Regulations 2017, the information contained within the Quality Account has been reviewed and checked against data sources, where this is available, and confirm this to be accurate and fairly interpreted to the best of our knowledge.

During 2024/25 the Nursing and Quality Team have worked closely with the Trust, meeting routinely to review a range of areas related to both quality and safety, for example regarding paediatric audiology services. We expect this joint work to continue in 2025/26 to deliver the transformation required.

The ICB has also worked in partnership with the Trust to undertake Partnership Quality Visits using an improvement approach to support driving improvements in patient safety and experience.

The Trust's Care Quality Commission (CQC) rating has remained as 'Requires Improvement'. The Trust continue to focus on their CQC Improvement Plan and progress is regularly reported to the ICB as well as the Trust Board and CQC. The ICB notes that in 2024/25 the Trust's Maternity service successfully stepped down from the National Maternity Safety Support Programme.

During 2024/25 ENHTT achieved a range of results in areas regarding quality, patient safety and patient experience, and the ICB is pleased to see the progress so far in relation to Quality Improvements in these areas. This is particularly pertinent in relation to the recognition of deteriorating patients, the ongoing work of the Patient and Carers Experience programme, and the successful launch of the East and North Hertfordshire Production System leadership training programme.

The ICB notes the sepsis pathway compliance continues to be part of the Trust's sustainability plans for 2025/26. We will continue to seek assurance that this, alongside venous thromboembolism risk assessments, continues to move in the required direction and that related performance is sustained.

The Summary Hospital-level Mortality Indicator data reported throughout the year is positioned in the 'as expected' range. It is encouraging to see the work undertaken to reduce mortality and ensure learning and robust processes are in place.

In relation to Infection Prevention Control (IPC), the Trust reported two MRSA bacteraemia cases for 2024/25 with post infection reviews held to ensure actions from the learning were carried out and sustained. Cases of Clostridium difficile have reduced by 6.5% compared to the previous year and cases have undergone a review, to support learning and improvement, and the aligned work undertaken by the IPC team in providing education, training and support is also noted. The ICB will continue to have oversight and seek assurance regarding Clostridium difficile cases for 2025/26.

During 2024/25 the Trust reported 5 Never Events; an increase from the two reported the previous year. The ICB notes the Trust's ongoing actions and identified learning related to these incidents to prevent similar incidents in future, as well as engagement with the wider system work to encourage learning from Never Events is identified and shared. The ICB will continue to monitor this closely and offer support to ensure learning is appropriately embedded.

The timeliness of complaint responses has seen an increase in performance during 2024/25 and the Trust recognises the sustained focus required to meet the complaint responsiveness target. The ICB acknowledges the ongoing work related to strengthening complaints resolution and responsiveness and looks forward to seeing continued improvements in this area and in ensuring that patients and families receive prompt responses to concerns raised.

During 2024/25, the Trust reported on three national cancer standards. For the 28-day faster diagnosis standard, the Trust has consistently met the target threshold throughout the year and the Trust's early adoption of the NHS England cancer pathway analyser tool has supported improvements and has been nationally recognised. For the 31- day treatment standard the Trust has also met the target throughout the year with the exception of one month. For the 62-day treatment standard, while not consistently sustained, the Trust's performance against this standard has remained one of the strongest regionally and among the top ten performing trusts nationally. The ICB is pleased to see that improvements continue to be made and would encourage the Trust to sustain a strong commitment and focus in this area.

In 2024/25, the Trust continued to work towards the national four-hour emergency care standard, achieving 73.18% which is a 10% improvement year-on-year. The Trust have progressed a system-wide emergency care transformation programme aimed at reducing unnecessary Emergency Department attendances, improving flow, and enhancing patient experience. Key developments included the formal re-establishment of the Surgical Assessment Unit, the launch of the Surgical Same Day Emergency Care service and the Adult Urgent Treatment Centre. In 2025/26 the ICB would like to see the Trust focusing on its work with partners to improve the experiences for patients who access urgent and emergency care services.

The 2024 annual National staff survey results for the Trust showed improvements in all categories and the Trust was recognised as the 4th most improved Trust nationally. The ICB recognises the ongoing work and commitment within the Trust in progressing the identified themes of the staff survey.

The ICB acknowledges ENHTT for their dedication in implementing the Patient Safety Incident Response Framework (PSIRF), strengthening how the NHS learns from patient safety incidents to enhance care and outcomes. We will continue our joint working with ENHTT and system partners as part of continued progression with PSIRF and the National Patient Safety Strategy and recognise that evidencing key principles such as compassionate engagement, proportionality, and system-wide approaches will be vital to ensure its ongoing success.

Looking forward to 2025/26, the ICB supports ENHTT quality priorities, and we look forward to a continued collaborative working relationship, including through building on existing successes and collectively taking forward needed improvements to deliver high-quality services for this year and thereafter.

Sharn Elton
Place Director,
East and North Hertfordshire Hertfordshire and West Essex ICB

Healthwatch Hertfordshire's response to the East and North Hertfordshire Hospital NHS Trust (ENHT) Quality Account 2024/2025

Healthwatch Hertfordshire is pleased to provide a response to ENHT's Quality Account 2024/25.
ENHT demonstrates a learning culture with a good level of openness in the Quality Account and has been open to Healthwatch Hertfordshire being a critical friend, with opportunities for us to be involved in their public Trust Board meetings. Over the past year, conversations about the best ways to communicate and engage with patients in their community have been rightly high on their agendas, and we continue to be a supporting partner in making sure patient voices are part of their decision making.

Collaborative work with system partners is evident. For example, the work with the East of England Ambulance Service NHS Trust (EEAST) and other partners including Hertfordshire Community NHS Trust, primary care, and other acute providers to improve ambulance handover times to under 30 minutes and seeing a positive trend (although understandably winter pressures created a blip in performance). The Acute Provider Collaboration also enables better working across partner trusts.

We are pleased to see that advance care planning is continuing to be a focus. We are doing a piece of work on advance care planning together with resources on ageing well and working closely with charities which support people. We would be interested in collaborating on this work or would be happy to share with ENHT once completed (at the end of 2025).

We welcome the explicit focus on tackling health inequalities (Priority 6) around paediatrics and maternity. We know from our Making Local Healthcare Equal: Healthcare Concerns in Black and Asian Communities | Healthwatch Hertfordshire that Black and Asian people experience significantly poorer health outcomes than their White counterparts. As reducing health inequalities is a key area our own work, we would welcome collaboration with the Trust.

We commend the work on Priority 3 'Patient and Carer Experience Programme', and the Trust's acknowledgement that there is still more to do. We look forward to seeing how this programme develops in the coming year particularly around complaints responsiveness.

Children's community waits are a significant area of concern in Hertfordshire, and we particularly note the ongoing work on the Trust's Paediatric Audiology Services and commend the system collaborative work and mutual aid and support from other organisations to improve the situation for families and children. We hope to start seeing improvements in the coming year.

We congratulate the Trust on being named the most improved Trust in the 2023 CQC governance maternity survey, showing how the Trust is building up the quality of their services especially since the National Maternity Improvement programme inspection in 2023, although we note that the highest number of Speak Up incidents being reported from staff are still in Nursing and Midwifery so a continued focus on this is important.

We welcome the rollout of a new unified Electronic Patient Record (OneEPR) and the ambition to streamline outpatients and improve patient access and choice. However, our recent work looking at online GP services highlighted that many people were concerned about the accessibility of online services and the impact digitalisation may have on those who struggle to use technology. We hope that ENHT's enhanced patient, community engagement and embedded coproduction processes will be fully utilised in understanding what patients need to engage effectively with the system. We would be happy to share our expertise on coproduction and engagement with the Trust.

To reduce the risk of patients deteriorating, we particularly note the work to implement Martha's Rule (a patient safety initiative for families and staff to call for an independent review if they are concerned about a patient's deterioration). At the Trust this is known as Call for Concern, and we know that the Trust is doing a

lot of work around this to ensure families are listened to by analysing how it is working in order to raise awareness and improve communications to engage wider areas of the community.

We congratulate the Trust on their work on safeguarding and the plans for sustainability in 2025/26 and in particular to better meet the needs of individuals with learning disabilities and autism.

We welcome the continued focus on staff engagement and morale and the 'A Voice That Counts' work, focussing on how staff concerns about unsafe clinical practice are captured, shared, and acted upon through the Freedom to Speak Up Champions. The Trust is rightly proud that it is nationally recognised as the 4th most improved trust in its survey results. We also note the focus on reducing discrimination via the Equality Diversity and Inclusion strategy and Steering Group. Our research on the experience of International Recruits in the NHS highlights the support that staff need in their roles. Retaining and supporting staff to provide high quality care is crucial to ensuring patient safety and experience.

We look forward to continuing to work closely with the Trust to help enhance opportunities for patient voices to be heard and services to be improved, including supporting the quality priorities outlined in this Quality Account.

Neil Tester, Chair Healthwatch Hertfordshire
June 2025

Statement from Social Care Health and Housing Overview and Scrutiny Committee.

Central Bedfordshire Council's Social Care Health and Housing Overview and Scrutiny Committee holds decision-makers to account for improving outcomes and services for the residents of Central Bedfordshire. As a critical friend to the Trust, we are pleased to have an opportunity to provide feedback on the Trust's Quality Account for East and North Hertfordshire NHS Trust.

We would like to start by acknowledging the many highlights and achievements delivered by the Trust during the last year.

We make specific reference to:

- being named the most improved Trust in the 2023 CQC governance maternity survey having performed significantly better in 15 areas.
- The focus on improving patient safety and the resulting 20% increase in incident reporting and improved thematic reviews which we hope reflects improved awareness of the importance of patient safety within the Trust.
- We also welcome the improvement in staff survey results, and the Trust's standing as the fourth most improved Trust nationally.

We welcome the inclusion of the quality priority 5 focused on Person-Centred and Seamless Pathways and hope that this work helps to ensure that care is accessible, timely, and of high quality and focuses on engaging and empowering people to take an active role in their health. In addition, that quality priority 6 Tackling Health Inequalities and Promoting Equity seeks to address the disparities in health outcomes and access to care that exist among different population groups.

We also welcome the focus in the coming year on the rollout of a new unified Electronic Patient Record and hope that this will offer patients a more joined-up and efficient service from the Trust and allow for more efficient working between teams and departments as well as improved patient communication.

We highlight the following areas of concern and areas for improvement.

- That the Trust's current registration status with the CQC is 'requires improvement.' We would welcome more detail in the report on the actions the Trust is undertaking in order to address the areas of concern identified in the most recent CQC inspection.
- The Trust's performance in meeting the national four-hour emergency care standard remains below the target, with a current performance of 74% although we recognise the focus on delivering improvement against this target over the past year including the extension of the Same Day Emergency Care service hours.
- The continued challenge of reducing ambulance handover times and the need for further progress on this, an area which has been of particular interest to the Committee over the past year.
- The Trust has not fully met the national target of less than 1% of patients waiting over six weeks for a diagnostic test.
- The Trust's responsiveness to formal complaints has improved but still falls short of the 80% target, with 68% of complaints responded to within the agreed timeframe.

We would like further information in the future illustrating the ways in which patients and the public were involved with the production of the Quality Account. We would also like to see an Executive Summary included in the report with summaries of key achievements and key areas of concern. We also believe that important information, such as the Trust's CQC rating, and learning from deaths workstream would benefit from being more prominent in the document with a clearer summary of action going forward.

In conclusion we welcome the opportunity to consider and comment on the report and we look forward to working constructively with the Trust to support the scrutiny process and our residents.

Cllr Emma Holland-Lindsay,
Chair, Central Bedfordshire, Social Care Health and Housing Overview and Scrutiny Committee.

Statement of adjustment following receipt of written statements required by section 5(1) (d) of the National Health Service (Quality Account) Regulations 2010

There are no major adjustments to be made following the receipt of written statements.

Annex 2: Statement of Directors' Responsibilities

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011, 2012, 2017 and 2020).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the trust's performance over the period covered.
- the performance information reported in the Quality Account is reliable and accurate.
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

28 June 2025 Date Chair

28 June 2025 Date Chief Executive

Glossary

Acronym	Meaning
AAR's	After Action Review
AMS	Antimicrobial Stewardship
B. I	Business Intelligence
C-DIFF	Clostridium difficile
CCU	Critical Care Unit
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DSAT	Domestic and Sexual Abuse Team
DSPT	Data Security and Protection Toolkit
Enhance	Trust's Risk and Incident Management System
ENHT	East and North Hertfordshire NHS Trust
ENHPS	East and North Herts Production System
ED	Emergency Department
ePMA	Electronic Prescribing Medicines Management
EPR	Electronic Patient Records
EOLC	End of Life Care
FFT	Friends and Family Test
GDPR	General data protection regulation
GSF	Gold Standards Framework (for End of Lice Care)
H@H	Hospital at Home
HAT	Hospital acquired thrombosis
HSMR	Hospital Standardised Mortality Ratio
ICB	Integrated Care Board
IPC	Infection Prevention and Control
KPI	Key Performance Indicator
LocSIPPs	Local Safety Standards for Invasive Procedures
MRSA	Methicillin-Resistant Staphylococcus Aureus
NHS	National Health Service
NIHR	National Institute for Health Research
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
PROM	Patient Reported Outcome Measures
PSIRF	Patient Safety Incident Response Framework
QI/P	Quality Improvement/Project
RCA	Root Cause Analysis
PIFU	Patient initiated follow up
RTT	Referred to Treatment
SDEC	Same day Emergency Care
SHMI	Summary Hospital Level Mortality Indicator
SJR	Structured Judgement Review
SJRPlus	Structured Judgement Review Plus
SUS	Secondary Uses service
QI	Quality Improvement
VTE	Venous thromboembolism

East and North Hertfordshire Teaching NHS Trust

Board
Appendix 1

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	4a	
Report title	Quality Priorities 2025/2026		**Meeting Date**	30 June 2025	
Author	Associate Director of Quality Governance				
Responsible Director	Director of Quality Chief Nurse				
Purpose	**Assurance**	☐	**Approval/Decision**	☒	
	Discussion	☒	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☒	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

The proposed Quality Priorities for 2025-26 represent a strategic consolidation and evolution of our quality agenda. The framework demonstrates reasonable assurance through:

- Evidence-based priority selection driven by divisional engagement, risk assessment, and performance data
- Clear accountability structures with cross-divisional ownership and defined success measures
- Integration of 2024/25 learning, particularly around Never Events and procedural safety
- Maturity of previous priorities (Medicines Management, End of Life Care, Safeguarding) into business as usual
- Systematic approach to addressing fundamental care standards and governance gaps identified across all divisions

Key actions to strengthen assurance:
Quarterly divisional reporting to TMG/QSC, standardised governance tools implementation, and enhanced cross-divisional collaboration mechanisms.

Summary of key issues:

This paper presents six Quality Priorities for 2025-26, structured around

- Patient Safety,
- Quality Improvement,
- Patient Experience, and
- Health Equity themes.

The priorities consolidate fragmented improvement efforts into a cohesive framework that addresses fundamental care standards, embeds learning culture through PSIRF, develops QI leadership capability, drives digital-enabled pathway transformation, ensures seamless patient transitions, and tackles health inequalities.

Three 2024/25 priorities are recommended for business as usual, while invasive procedure safety and sepsis management are embedded within the new framework following significant safety events.

Impact: *tick box if there is any significant impact (positive or negative):*

Patient care quality	☒	**Equity for patients**	☒	**Equity for staff**	☒	**Finance/ Resourc -ing**	☐	**System/ Partners**	☒	**Legal/ Regul- atory**	☒	**Green/ Sustai- nability**	☐

The six Quality Priorities deliver strategic impact by addressing the Trust's highest Board Assurance Framework (BAF) risks and advancing all four strategic objectives through cross-divisional, integrated work streams. They strengthen patient care and equity through standardised fundamentals and targeted action on health inequalities; support workforce development through leadership and learning culture; and improve service delivery via digital transformation and person-centred transitions.

More than operational improvements, these priorities act as risk mitigations responding directly to BAF Risks 1 (Workforce), 2 (Population Needs), 5 (Culture & Leadership), and 12 (Clinical Engagement), as well as key safety themes such as the five Never Events in 2024/25.

The framework embeds continuous improvement and equity into all areas of transformation, aligning with regulatory standards, supporting PSIRF maturity, and enabling the Trust to meet its long-term strategic commitments with system-level collaboration and robust executive oversight

Trust strategic objectives: *tick which, if any, strategic objective(s) the report relates to:*

Quality Standards	☒	**Thriving People**	☒	**Seamless services**	☒	**Continuous Improvement**	☒

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

Direct BAF Risk Alignments:

- BAF Risk 1: Workforce requirements (Score 12) - Fundamental care standards require appropriate staffing levels and skill mix
- BAF Risk 2: Population/stakeholder needs (Score 12) - Health inequalities and patient experience priorities directly address population needs
- BAF Risk 5: Culture, leadership and engagement (Score 16) - Learning culture and QI leadership development are critical enablers
- BAF Risk 12: Clinical engagement (Score 12) - PSIRF embedding and pathway transformation require sustained clinical buy-in

Report previously considered at & date(s):

Considered at the Trust Management Group- 1st scrutiny and agreement- 12th June 2025 and at Quality and Safety Committee at their 25 June 2025 meeting.

Recommendation	The Board is asked to 1. Review and Endorse the proposed Quality Priorities for 2025-26. 2. Note the success measures and reporting arrangements with accountability held by Divisions specific to delivery resourcing, Q1-Q2 priority phasing, and how themes from BAU and strategic oversight items (e.g., Invasive Procedures) will be monitored without priority status. 3. Support the proposed reporting cadence, including quarterly divisional reporting into TMG and QSC.

To be trusted to provide consistently outstanding care and exemplary service

ENHT Draft Quality Priorities 2025- 2026

1. Background
   1.1. It is a requirement of the Quality Account that Trusts include a rationale for the selection of the Quality Priorities and how these decisions were reached.
   1.2. Quality priorities should be visible to staff across the Trust and relevant to improve practice

2. Proposed Quality Priorities for 2025-26
   2.1.1. Based on discussions with Divisional leads, divisional priorities, and identified risks, the following quality priorities are proposed for 2025-26.
   2.1.2. A broader lens view frames our quality priorities structured around under 4 main themes: Patient safety, Quality improvement, Patient Experience, and Health Equity.

   Patient Safety
   - QP 1: Strengthening Fundamentals of Care & Governance
   - QP 2: Embedding a Learning Culture and PSIRF
   - QP 4: Quality-Driven Pathway Transformation (incl. Digital)

   Quality Improvement
   - QP 3: Embedding Leadership for Quality Improvement

   Patient Experience
   - QP 5: Person-Centred and Seamless Pathways

   Health Equity
   - QP 6: Tackling Health Inequalities and Promoting Equity

   2.1.3. These priorities are categorised under Darzi headings of Effective, Safe, Patient Experience and Well- led with alternative framing broader lens provided below
   2.1.4. Divisional Accountability**:** All six priorities are cross-divisional by design and delivery, requiring multidisciplinary input across clinical, digital, operational, and strategic services.
   - Shared Tools: All priorities encourage use of PSIRF tools, ENHPS, and OneEPR for consistency
   - Themes of Collaboration: Communication, governance maturity, and digital enablers are common threads.

   2.1.5. Quality Reporting: Progress will be reviewed quarterly at Divisional Boards, then reported to TMG and QSC.

   2.2. The following Quality Priorities from 2024-25 are proposed to be absorbed into 'business as usual' in 2025-26. These priorities have demonstrated sustained improvement, process maturity, and integration into routine practice

   2.2.1. Medicines Management and Antibiotic Stewardship
   - Rationale: Full implementation of the medicines optimisation strategy, with high compliance in stewardship reviews and electronic prescribing.
   - Status: Performance targets largely met; embedded within clinical and pharmacy workflows.
   - Next Step: Monitor through Divisional Governance and Clinical Effectiveness forums.

   2.2.2. End of Life Care – Gold Standards Framework (GSF)

- Rationale: Phase implementation complete across key wards, accreditation processes and measurable patient benefits are embedded.

- Status: Sustained ward adoption, with routine audits and leadership in place.
- Next Step: Sustain through divisional quality leads and GSF champions.

2.2.3. Safeguarding Oversight

- Rationale: Strong governance infrastructure, multi-agency collaboration, improved referral quality, and staff engagement through training.

- Status: Fully embedded; LPS transition readiness supported through national guidance adaptation.

- Next Step: Oversight via the Safeguarding Committee and mandatory compliance reporting.

2.3. The following quality priorities from 2024/25 remain critical to the Trust's ongoing safety, learning, and transformation agenda. They will continue under strategic oversight by being embedded into the 2025–26 Quality Priority framework.
This approach minimises duplication, strengthens thematic alignment, and maintains a clear focus on areas of known risk, operational variation, or cultural maturity gaps while leveraging established governance structures to support accountability and delivery.

2.3.1. Invasive Procedure Safety

- Rationale: Despite >90% compliance in audits, five Never Events in 2024/25 including wrong site surgery, incorrect prosthesis, and retained swab, highlight cultural and behavioural safety gaps.
- Focus: Standardising safety huddles, LocSSIP documentation, whiteboard use, and theatre list sign-off processes.

Action:

- Embedded within 2025/26 Priority 1 (Fundamentals of Care) and Priority 2 (Learning Culture & PSIRF)
- Never Event learning incorporated into Trust-wide PSIRF learning responses.
- Human factors and behavioural reliability (checklist consistency) built into governance standards.
- **Reporting:** Monitored through PSIRF thematic reviews and divisional quarterly governance packs

2.3.2. Sepsis and Deteriorating Patient Management

- Rationale: Ongoing variation in clinical escalation behaviour and outstanding PSII learning; improvement needed in timely recognition and response.
- Focus: NEWS2 standardisation, escalation response times, digital workflow integration (e.g. EPR), and equity of care delivery
- Action:
  - Embedded within 2025/26 Priority 1 (Fundamentals of Care & Governance)
  - PSII learning linked to escalation and safety culture improvement
  - **Reporting:** Audited through the Deterioration Steering Group; included in divisional compliance dashboards.

2.4. Detailed plans and how we will evaluate success for each of the proposed Quality Priorities for 2025-26 can be seen in Appendix 1.

APPENDIX 1

Quality Priorities 2025 to 2026

Domain	Quality Priority	Key Focus Areas	How We Measure Success
Safe	**#Priority 1** Strengthening Fundamentals of Care & Governance (**All Divisions)**	• Daily incident huddles to support safety culture • Embedding of PSIRF processes at ward and site level • Governance standardisation • Closing the loop on learning from harm Safe staffing, core standards (NEWS2, escalation)	• Reduction in overdue incident closures • Compliance with core standards (NEWS2, Obs, escalation) • Staff feedback on basic care delivery

Strategic Objective Alignment: We deliver safe and effective care.

All divisions have identified concerning variation in fundamental care standards, governance processes, and escalation practices. From elective recovery issues in Planned Care to inconsistent NEWS2 use in Unplanned and Women & Children's, variability in care basics continues to impact safety, flow, and patient experience.

Internal audits, incident reviews, and ENHance data confirm these risks: overdue incident closures, compliance gaps in early warning scores, and inconsistent handover practices affect patient outcomes and staff confidence across all care settings.

Why This is a Trust-wide Priority:

Frontline teams have consistently highlighted that safe, coordinated care depends on getting the fundamentals right. Escalation protocols, staffing visibility, documentation standards, and governance maturity aren't standalone tasks—they're foundational enablers for all other quality improvements.

Formalising this priority delivers:

- Unified standards: A Trust-wide approach to core care delivery, replacing inconsistent local practices with standardised, evidence-based protocols
- Data-driven oversight: Governance tools and systematic monitoring that identify and address variation before it impacts patients
- Systematic risk management: Integration of high-risk themes from 2024/25—including deteriorating patient management and sepsis—into a sustainable framework for long-term improvement
- Local accountability**:** Clear ownership and escalation pathways that ensure basics are consistently delivered across all divisions and care settings

This priority acknowledges that excellence in specialised care is impossible without mastery of fundamental care standards. This priority supports the systematic, sustained effort required to embed these basics across the Trust.

<table>
<tr><td rowspan="2">Well- Led</td><td>#Priority 2

Embedding a Learning Culture and PSIRF

(Planned, Unplanned & Cancer Services)
(Trust-wide Governance)</td><td>• Trust-wide PSIRF training and learning response adoption
• Consistent incident response tools (e.g., Swarms, AARs)
• Leadership visibility on safety themes and closures
• Systematic use of governance tools and the Good Governance Matrix</td><td>• % learning responses completed using PSIRF tools
• Audit compliance with learning closure loops
• Safety culture metrics (staff survey, FTSU themes)
• Standardised reporting across divisions</td></tr>
<tr><td colspan="3">Strategic Objective Alignment: We are a learning organisation
The first full year of PSIRF implementation has revealed significant variation in how safety learning is applied across the Trust. While Cancer Services demonstrated maturity through the Good Governance Matrix and 30+ PSIRF tools, other divisions show inconsistent use of swarms, after-action reviews, and incomplete learning loops.
Freedom to Speak Up data and Patient Safety Incident Investigation reviews highlight a cultural challenge: learning isn't consistently visible, owned, or acted upon at all levels, creating strategic risk to our improvement capabilities and harm prevention.

Why This Must Be a Trust-wide Priority
PSIRF is no longer new—it's the national expectation for NHS patient safety response. We're at a critical inflection point where embedding learning culture is essential for maturing safety governance, reducing variation, and sustaining improvement.
This priority delivers:
• Consistent learning systems: Standardised use of PSIRF tools and processes across all divisions, eliminating current variation in safety learning application
• Cultural transformation: Shift from reactive learning to proactive safety culture where insights consistently drive action and improvement becomes part of daily practice
• Strategic integration: Absorption of 2024/25 invasive procedure safety focus (following five Never Events) into routine improvement systems, ensuring human factors and procedural learning are systematically embedded
• Organisational maturity: Trust-wide capability to turn safety events into sustainable improvement, supported by governance structures that ensure learning translates to action
By prioritising this work, we're committing to move beyond incident investigation to genuine learning culture—where every safety event strengthens our ability to prevent future harm across all care settings.</td></tr>
</table>

Well- Led	**#Priority 3** Embedding Leadership for Quality Improvement **(Trust-wide leadership and divisional QI leads)**	• Continued leadership development and ENHPS implementation • Divisional QI projects aligned to Trust priorities • Inclusive and resilient clinical engagement • Expansion of QI capability through coaching and training	• ENHPS adoption rates • Participation in QI training • Divisional QI initiatives linked to Trust goals • Clinical engagement metrics"

Strategic Objective Alignment: We lead and support our staff

In 2024/25, our strategic goal was to deliver safer, more efficient, and compassionate care by embedding continuous improvement across all levels of the organisation. This included a commitment to zero harm, empowering staff through leadership and improvement capability, working in partnership to enhance services, and making best use of our resources.

Leadership Live and divisional engagement revealed significant variation in quality improvement capability, clinical leadership engagement, and divisional ownership of improvement agendas. While transformation programmes exist, inconsistent QI leadership and local accountability has limited our ability to scale learning, reduce variation, and sustain improvements.

Cancer Services piloted governance diagnostics and embedded improvement in pathway redesign, while Planned Care led Lean workshops in ophthalmology and elective recovery. However, staff feedback revealed gaps in consistent QI leadership and local accountability, limiting the scale and sustainability of improvement.

Why This Must Be a Trust-wide Priority

Our 2025/26 shift to multi-year strategic goals reinforces leadership and QI capability as foundational enablers of transformation. Without skilled, empowered leaders at every level—clinical and operational—we risk stagnation in quality metrics, limited innovation adoption, and widening service gaps.

This priority delivers:

- System resilience: QI capability distributed across all divisions, not dependent on small numbers of individuals or corporate teams
- Leadership accountability: Improvement embedded as core leadership expectation, with clear ownership and local responsibility for quality agendas
- Capability building: Confident, skilled leaders who can effectively lead and contribute to improvement initiatives, supported by structured development programmes
- Strategic alignment: Stronger connection between frontline teams and Trust-wide goals, ensuring improvement efforts directly support organizational priorities
- Sustainable transformation**:** Foundation for every other quality priority to succeed through consistent, skilled leadership driving continuous improvement

Investing in leadership for improvement isn't optional—it's the mechanism by which safer, more efficient, and compassionate care will be delivered consistently across all services. Without this foundation, our other quality ambitions cannot be realised or sustained.

Effective	**#Priority 4** Quality-Driven Pathway Transformation (incl. Digital) **(Planned Care, Digital, Estates, Cancer)**	• Elective and emergency pathway redesign (same-day surgery, emergency theatre access) • Use of digital tools (OneEPR, remote MDTs, ePROMs) • Outpatient transformation and centralised booking • Estates improvements to streamline care delivery • 100% completion of medical devices and RFID tags	• Improved waiting times & pathway efficiency (theatres, diagnostics) • Adoption of OneEPR functions • Increase in care closer to home (e.g. SACT) • Effective tracking and management of all medical devices.

Strategic Objective Alignment: We use our resources wisely; we improve services

Fragmented care pathways undermine safety, timeliness, and patient experience across Planned Care and Cancer Services. With growing waiting lists and system complexity, both divisions have identified the same solution: integrated, digitally enabled pathways that eliminate inefficiencies and deliver coordinated care.

GIRFT reviews, theatre productivity analysis, and digital strategy work confirm our current pathway models are inadequate. Planned Care is advancing same-day surgery and infrastructure redesign, while Cancer Services expand virtual MDTs and localize systemic therapies. Digital optimization across outpatients, theatres, and diagnostics—integrated with our RFID and medical devices programme—will reduce delays, improve flow, and enable safer, more predictable care.

Why This Requires Trust-wide Priority Status

While transformation efforts are active across divisions, progress remains fragmented and inconsistently resourced. Elevating this to a formal Quality Priority will:

- Align multiple initiatives: OneEPR, RFID, outpatient transformation, and theatre redesign currently operate in silos, requiring greater coherence to maximise impact and reduce duplication
- Provide executive authority: Formal prioritisation delivers cross-divisional leadership backing needed to address barriers like siloed ownership, workforce readiness, and digital maturity gaps
- Enable shared governance: A unified quality framework creates shared metrics, real-time tracking, and collaborative learning structures that elevate performance Trust-wide
- Accelerate pace and scale: Formal designation supports resource allocation, TMG and QSC oversight, and ensures consistent approaches to removing inefficiencies that directly impact patient outcomes

We're not starting from scratch—we're scaling what works, closing variation, and embedding pathway transformation as core to delivering safe, efficient, patient-centred care.

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<table>
<tr><td rowspan="2">Patient Experience</td><td>#Priority 5

Person-Centred and Seamless Pathways

All divisions (esp. Women & Children’s, Unplanned Care, Cancer)</td><td>• Improved discharge coordination and continuity of care
• Establish effective seamless pathways in maternity - reducing delays in transfer of IOL’s to delivery suite by 50%
• MDT planning and personalised transitions
• Reduction in readmission through seamless step-down care</td><td>• Discharge planning compliance
• Readmission rates
• PALS/complaints themes on transitions
• MDT care planning audit
• Pathway completion rates (children completing full care pathway)
• Percentage of IOLs transferred within target timeframe (e.g., <2 hours)</td></tr>
<tr><td colspan="3">Strategic Objective Alignment: We provide responsive, compassionate care
Why is this a priority?
Across the Trust, a clear theme has emerged: patients and families often experience our care transitions as inconsistent or disjointed. This was highlighted in divisional discussions, where challenges in coordination, communication, and continuity of care were repeatedly raised.

• Women & Children’s noted variation in neonatal discharge planning and the experience of carers navigating the system.
• Unplanned Care identified delays in discharge and inconsistent step-down processes, particularly affecting complex and frail patients.
• Planned Care cited gaps in follow-up processes and the need for more personalised information exchange.
• Cancer Services underscored these themes through fragmented transitions across diagnostics, systemic therapy, and acute oncology support.

PALS data, complaint themes, and PSII reviews consistently reinforce these concerns, particularly around discharge communication, care handovers, and delays. These signals suggest a need to strengthen cross-service coordination and ensure greater clarity and consistency in how transitions are managed.

Why now?
As our clinical and digital models evolve -through virtual care, outpatient redesign, and shifting inpatient pressures- we must ensure these changes improve, not complicate, the experience of moving between care settings. Seamless care is not just about speed; it’s about ensuring every patient and carer knows what to expect, who to contact, and how their journey is being managed.
This priority unites several strands of existing work including relational discharge planning, MDT coordination, and carer involvement; into a focused effort to improve the experience and reliability of transitions across the Trust. It supports our goal of delivering care that is predictable, compassionate, and clearly communicated at every stage</td></tr>
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<tr><td></td><td colspan="3">The integration of the 2024/25 PACE workstream ensures that relational care, compassionate discharge, and carer involvement are directly addressed through a unified quality perspective.</td></tr>
<tr><td></td><td>#Priority 6

Tackling Health Inequalities and Promoting Equity

(Women & Children’s, Cancer, Trust-wide Strategy)</td><td>• Targeted equity actions in maternity and paediatrics
• NICU outreach and community transition models
• Expanding access to cancer treatment closer to home
• Use of local population data to prioritise access improvement'</td><td>• Reduction in access gaps (e.g. Paediatrics, NICU outreach
• Development & triangulation of Local data on underserved populations
• Patient engagement feedback loops</td></tr>
<tr><td></td><td colspan="3">Strategic Objective Alignment: We address health inequalities
Why is this a priority?
Despite improved clinical outcomes overall, significant disparities persist in how different communities access and experience care, particularly in maternity and neonatal services. Women from Black and minority ethnic backgrounds and those in deprived areas continue to face poorer perinatal outcomes and barriers to culturally responsive care.

Our digital transformation initiatives risk deepening these inequalities without proactive measures to address digital exclusion. While we have made progress in embedding patient voice and co-production, lived experience must more meaningfully inform care redesign.
The Trust recognises that staff experience directly impacts patient equity. Workforce representation, inclusive practice, and leadership accountability are essential for delivering equitable care. These systemic gaps require urgent, intentional action.
Cancer Services will actively contribute to this agenda, using local population data to identify screening gaps, improve access to early diagnosis and treatment closer to home, and ensure inclusivity in care planning and clinical trials. These actions mirror the efforts in maternity and highlight a broader need to address equity across the full care continuum.

This priority builds on strategic partnerships and ICS commitments, and aligns with work led by the Trust’s Strategy Directorate. It ensures that equity remains a deliberate design principle within all pathway and service transformations.</td></tr>
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