Public Trust Board

ENHPS Hub - Old School of Nursing, Lister Hospital, Stevenage SG1 4AB

13/05/2026 09:30 - 12:00

10.	Learning from deaths report	Medical Director	10:35-10:45	29
For assurance				
BREAK		Trust Chair	10:45-10:55	
11.	Annual review of Standing Orders, Scheme of Reservation and Delegation & Standing Financial Instructions	Chief Finance Officer	10:55-11:05	42
For endorsement				
12.	Board Assurance Framework (BAF) - Strategic risks	Head of Corporate Governance	11:05-11:15	151
For approval				
13.	Integrated Performance Report	Chief Kaizen Officer	11:15-11:35	158
For discussion				
14.	Quality and Safety Committee (QSC) report to board - 25/3/26 & 29/4/26 (verbal)	QSC Chair		208
For discussion				
15.	Finance, Performance and Planning Committee (FPPC) report to board - 23/3/26 & 27/4/26 (verbal)	FPPC Chair		210
For discussion				
16.	People and Culture Committee (PCC) report to the board- 21/4/26	PCC Chair		212
For discussion				
COMMITTEE REPORTS			11:35-11:50	
17.	Health Care Partnership (HCP) verbal report to the board	Chief Executive		214
For discussion				
17.1	ENH HCP Committee terms of reference	Head of Corporate Governance		214
For approval				
18.	Audit and Risk Committee (ARC) report to board - 31/03/26 & 14/04/26	ARC Chair		223
For discussion				
19.	Digital Committee report to the board - 07/04/26	Digital Committee Chair		227
For discussion				
20.	Remuneration Committee terms of reference	Head of Corporate Governance		229
For approval				
OTHER ITEMS			11:50-12:00	

21.	Annual Cycle	Trust Chair	234

For noting

22.	Any Other Business	Trust Chair

For noting

23.	Date of Next Meeting	Trust Chair

Wednesday, 8 July 2026 to be held online

ASSURANCE RATING GUIDE

Whilst context and individual circumstances should be taken into account, the below descriptions are intended as an aid in applying and interpret ratings in a consistent way. The assurance rating is also intended to help identify where action is needed and level of monitoring required.

Assurance Rating	Description
Substantial	• Taking account of the issues identified, substantial assurance can be taken that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective.
Reasonable	• Taking account the issues identified, reasonable assurance can be taken that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. • However, issues have been identified that need to be addressed in order to ensure the control framework is effective in managing the identified risk(s).
Partial	• Taking account the issues identified, partial assurance can be taken that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. • Action is needed to strengthen the control framework to manage the identified risk(s).
Minimal	• Taking account the issues identified, assurance cannot be taken that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. • Urgent action is needed to strengthen the control framework to manage the identified risk(s).

East and North Hertfordshire Teaching NHS Trust

Minutes of the Trust Board meeting held online on Wednesday, 11 March 2026 at 9.30am

Present:

Ms Anita Day (AAD)	Trust Chair
Dr David Buckle (DB)	Non-Executive Director
Ms Janet Scotcher (JS)	Non-Executive Director
Ms Gillian Hooper (GH)	Non-Executive Director
Mr Tichafara Phiri (TP)	NeXT Non-Executive Director
Ms Diana Skeete (DS)	Non-Executive Director
Mr Richard Oosterom (RO)	Associate Non-Executive Director
Ms Nina Janda (NJ)	Associate Non-Executive Director
Mr Adam Sewell-Jones (ASJ)	Chief Executive Officer
Ms Theresa Murphy (TM)	Chief Nurse
Ms Penny St Martin (PSM)	Chief People Officer
Mr Martin Armstrong (MA)	Chief Finance Officer and Deputy Chief Executive Officer
Dr Justin Daniels (JD)	Medical Director
Ms Lucy Davies (LD)	Chief Operating Officer
Mr Kevin Howell (KH)	Director of Estates and Facilities
Mr Kevin O'Hart (KOH)	Chief Kaizen Officer
Mr Mark Stanton (MS)	Chief Information Officer
Ms Eilidh Murray (EM)	Director of Communications and Engagement

From the Trust:

Ms Amanda Rowley (AR)	Director of Midwifery (26/035)
Ms Frankie Kilmurray (FK)	Consultant Midwife (26/035)
Mrs Debbie Okutubo (DO)	Deputy Company Secretary (Board Secretary - minutes)

No	Item	Action
	The Chair, AAD explained that due to a YouTube issue, the meeting would not stream live but was being recorded for upload. She welcomed Board members, attendees and a special guest speaker to narrate the staff story. It was confirmed that the agenda had been published on the website and seen by all Board members.	
26/026	**DECLARATIONS OF INTEREST** There were no new interests declared.	
26/027	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Professor Zoe Aslanpour, Non-Executive Director and Dean of the University of Hertfordshire Medical School, Mr Kevin O'Hart, Chief Kaizen Officer, Mr Stuart Dalton, Head of Corporate Governance and Ms Ivana Chalmers, Chief Executive, Healthwatch Hertfordshire.	
26/028	**STAFF STORY** The Chief People Officer, PSM introduced GP also known as B, Advanced Critical Care Practitioner (ACCP). He described his 25-year NHS journey from internationally educated staff nurse to ACCP and independent prescriber. B recounted joining the NHS in October 2000 as a staff nurse at another Trust, progression across ICU, completing courses and applying for more senior roles where he trained theatre and recovery nurses daily, emphasising leadership, teamwork and resilience. He transitioned to ACCP training and qualified in 2023 as an independent/supplementary prescriber and completed a Masters in Advanced Critical Care Practice in 2024. The Board was advised that his current ACCP practice included intubation and insertion of central lines, vas-catheters and arterial	

lines. He credited mentors (notably Wendy Collier (rtd)) and consultant colleagues and highlighted continuous learning in critical care.

It was noted that his personal journey to ENHT in 2002, was influenced by his (now) wife—also an internationally educated nurse and now a matron in Critical Care. He said he “came for love, stayed for purpose,” stressing that international recruitment, when nurtured, builds future leaders and long-term contributors.

The Chair thanked B for an inspirational presentation and opened for questions.

The Chief Executive, ASJ reflected on the interconnectedness of staff, including families working within the Trust and the importance of connecting all staff to organisational purpose, which underpinned retention and pride.

The Chief Operating Officer, LD asked what advice he would give his younger self arriving today. B advised maintaining focus on one’s career, setting time-bound development goals, leveraging support networks, and loving the work to sustain momentum. He described how he set six-month milestones to gain confidence with equipment and ICU practice.

RO asked about the ACCP’s interface with nurses and doctors. B stated that initially there was some confusion about the role but since 2021 it had become well known and ACCPs could now be described as a bridge between nurses and doctors. They performed advanced procedures, presented treatment plans on ward rounds, and provided continuity compared to rotating junior doctors. ACCPs also stepped to bedside nursing to support teams when required.

TM praised ACCPs as “the glue” across ICU teams and standards compliance.

NJ asked how the Board could support the next generation. B suggested having

- structured pathways,
- baseline programmes and
- ongoing support.

The Chair thanked B for his passion and commitment and closed the item.

The Board **NOTED** the staff story.

26/029 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 14 January 2026 was **APPROVED** as an accurate record of the meeting.

26/030 ACTION LOG

The Deputy Trust Secretary, DO provided an update on outstanding actions. It was noted that all actions were down as green. She noted that regarding the integrated performance report (IPR) quadrants, because they were a mix of different measures, the Executives felt that an overall assurance rating was not viable. The Chair proposed to pick that up separately with members.

The Board **NOTED** the status of the action log.

26/031 QUESTIONS FROM THE PUBLIC

There were no public questions.

East and North Hertfordshire Teaching NHS Trust

26/032 CHAIR'S REPORT

The Chair, AAD provided a verbal update, she commented that herself and the Chief Executive, ASJ attended a regional Chairs/CEs meeting with Sir Jim Mackey and that messages were consistent with prior regional challenges, and the meeting facilitated regional networking.

She highlighted the pending ICB reconfiguration effective from 1 April. Hertfordshire & West Essex ICB to merge with Cambridgeshire & Peterborough and Bedfordshire, Luton & Milton Keynes into Central East ICB.
The new ICB's five priorities broadly aligned with local HCP priorities, and there was work underway to ensure full alignment.

She also noted a positive Board to Board session with Hertfordshire Community Trust.

She commented that staff survey national results were due imminently, which would inform future actions.

The Board **RECEIVED** and **NOTED** the Chair's report.

26/033 CHIEF EXECUTIVE'S REPORT

The Chief Executive summarised key updates:

Planning & transformation: He commented that the planning for 2026/27 would focus on waiting times, productivity and financial challenge. A transformation programme, "Better Care, Better Value," was being built on top of the ENH production system, with targeted external expertise where needed.

Partnerships & research/education: There was continued engagement with the university, with the Vice-Chancellor visiting the Trust, as it becomes a medical school later in 2026. This would also support the Trust's trajectory toward potential university hospital status and strengthen the governance links via our Medical Director, JD and the Dean of the Medical School, ZA who was also a NED at the Trust.

Digital & capital investment:

- It was noted that OneEPR remained a core focus and that most outpatients could interact digitally via the NHS app for information and letters.
- Capital: The Trust's allocation for next year had significantly increased for specified projects, including a new paediatric unit to replace outdated facilities. It was noted that final NHSE sign-off was pending, and clinical teams were co-designing the new build.
- Funding had been secured for four new scanners (CT/MRI), upgrading the Urgent Treatment Centre (UTC) from a temporary to a built-for-purpose facility, and expanding Home Dialysis training/support capacity.

Recognition of ENHT staff: Mr Tim Lane had been appointed future President of the Royal College of Surgeons and Dr Jeanette Dixon chaired the Academy of Medical Royal Colleges Council.

KMc welcomed the capital investment for the paediatric ward and the UTC, stressing the transformational impact on patient environments.

TM reiterated the exemplary co-design by paediatrics and estates using the ENH production system and timed readiness.

The Chair concurred and noted positive personal experience at UTC while endorsing fit for purpose facilities.

The Board **RECEIVED** and **NOTED** the Chief Executive's report.

26/034 STRATEGIC GOAL CASCADE

The Chief Executive, ASJ presented on behalf of the Chief Kaizen Officer, KoH.

The Chief Executive summarised the approach and reminded the Board that the Trust's mission and 2030 vision had been translated into four guiding themes with one high-level annual priority to sharpen focus. It was noted that this formed part of the Trust's transformation programme.

Following the introduction, a Board discussion ensued.

RO stressed the need for quality objective-setting and end-to-end execution. He asked how or when assurance would move from partial to substantial. In response, the Chief Executive, described a compliance drive via the accountability framework, performance meetings and the expectation that compliance should now be insisted upon, with quality improving through discussions including during Grow Together reviews.

RO emphasised training in objective-setting and the Chief Executive cited the Leaders Programme which was now reaching more junior staff and a management development offer.

The Chair, AAD spoke about strengthening the Grow Together reviews, which included re-looking at the objective setting, measurements and accountability.

DS commented that it was a comprehensive report and asked about capturing and sharing good practice across the Trust. The Chief Executive described the plans to broaden cross-division learning via leadership live events.

JS urged that the Trust should minimise administrative burden during this transformation journey. The Chief Executive agreed but noted the value of dialogue to create buy-in. The Chief Nurse TM welcomed the production system's agility, inclusivity and a new ward managers' programme.

The Board **AGREED** to a **PARTIAL** assurance rating.

26/035 HOME BIRTHS

The Director of Midwifery, AR introduced FK, Consultant Midwife. FK summarised the coroner's prevention of future deaths (PFD) report.

Following the presentation, a discussion ensued.

DB commented that he supported home birth in principle but stressed the need for real understanding of risk and asked how the Trust assured informed decision making beyond a single consultation. FK described how a thorough home-based risk assessment was conducted.

TM commended the dynamic approach to informed consent and continuous risk monitoring and asked about capacity to maintain line-of-sight on individuals. FK commented that to date, birth option appointments were being met. She continued that the constraint was community midwife time commissioned for antenatal care as more time would enable deeper counselling. However, all midwives would have to deliver baseline counselling and escalate headline cases to the clinic.

RO asked about competence in a low-volume service and shared learning with other Trusts. FK spoke about enhanced training, including skills with a specific focus on home emergencies and communication. This also included planned joint work with the ambulance service which included evacuation and transfer. There were also the regional consultant midwife forums, and potential national group participation.

The Medical Director, JD thanked FK noting the approximately doubled risk for a first-time mother of perinatal death or severe neurological injury with home birth compared to hospital, and the balance required to convey risk without scaring women. JD expressed assurance in ENHT's response to DB.

KH asked about thresholds where the Trust could not safely allow a home birth for example due to environment or distance given a reported 100% completion of risk assessments. FK responded that staff safety was fundamental and where a home was not a safe workplace the Trust may decline on that basis but would then consider mitigations to avoid exposing mother or baby to clinical risk by disengaging.
It was noted that the Midwife-Led Unit (MLU) was able to provide a compromise "home-from-home" option in hospital.

AR added that while some relative risks had doubled, absolute risks remained low, and the local actions addressed failings seen in the external case.

The Chair thanked to the team for the excellent paper.

The Board **AGREED** to a **REASONABLE** assurance for maternity home birth arrangements and the improvement plan.

26/036 BOARD ASSURANCE FRAMEWORK

The Chair noted that two corporate risks had increased to 21:

- Risk 3 (Financial constraints) and
- Risk 7 - System instability.

The Chair invited the Chief People Officer, PSM to present the two spotlighted BAFs.

Spotlights were taken on BAF Risk 4, workforce morale whilst making savings and BAF Risk 5, leadership & engagement. Both risks were aligned to the People portfolio.

PSM reported that on BAF 4, workforce morale, the Trust would continue significant change over the next year. It was noted that a change audit was underway to collect qualitative insights. Early feedback had highlighted the need for more time to develop ideas and engage staff.

On BAF 5, leadership and engagement, she advised the Board that a recent executive discussion questioned whether the issue was unwillingness to take difficult decisions, or insufficient time to implement them before moving on. It was noted that further work was planned, hence a slight risk increase.

A Board discussion arose:
GH suggested dedicated informal time to explore leadership culture, given its centrality to success amid ongoing complexity. PSM agreed.

KMc challenged whether Risk 4 should be reduced yet, given lagging productivity, rising workforce numbers, and the scale of transformation ahead. KMc recommended tighter controls and vigilance. PSM agreed that actions may need further tailoring for the year ahead.

JS added context that Risk 4 reduction had reflected the administrative review phase concluding and concerns about the mutually agreed resignation scheme (MARS) impact.

The Chair emphasised the dynamic nature of scoring and the need to manage/mitigate risk during transformation.

The Board **AGREED** to a **REASONABLE** assurance rating on the BAF.

26/037 INTEGRATED PERFORMANCE REPORT (IPR)

The Chief People Officer, PSM presented this item and highlighted key points from all four quadrants: Quality, Operations, Finance, and People. PSM summarised by saying many areas showed “green shoots of improvement”, but finance remained a key area of focus.

Following the presentation, GH asked whether the Executive Team had looked for links between patient safety indicators, sickness absence and high bank staff usage. TM replied that staff shortages had prevented the Trust from opening extra wards or running additional planned lists. She said workforce pressure naturally affected quality indicators, and she mentioned the shortage of 1:1 enhanced care staff.

JD added that sickness had increased in areas where staff consultations were taking place, especially where jobs were at risk. He also said staff assaulted at work were more likely to be absent and that reducing violence and aggression was a major priority. PSM added that better rostering, strategic resourcing and giving staff dignity during organisational change were essential to reducing pressure.

GH commented that she appreciated the detailed answers.
GH asked a second question that with many diagnostics’ waits over six weeks, she wondered how RTT remained strong.

The Chief Operating Officer, LD replied that RTT performance was strong compared to other trusts, but less strong compared with pre-Covid days. Also, that around two-thirds of patients were under 18 weeks, whilst one-third waited longer.

The Board was also advised that some patients still waited over 52 weeks, but numbers were reducing. Diagnostic delays were largely in audiology, MRI,

ultrasound and CT. The Trust was trying to increase capacity in the modalities with the longest waits.

GH thanked LD for the clarity.

TP asked PSM about statutory and mandatory training compliance. He said that there were gaps and asked about the growing use of digital tools such as co-pilot. PSM replied that the Trust was reviewing whether all mandatory training was necessary and whether any could be removed or simplified. PSM continued that training should align with what kept patients safe and staff competent.
The Chief Executive added that nationally there was weak evidence for some mandatory training. He also said co-pilot had recently been switched on, and administrative teams were being engaged to drive practical use of AI across the Trust.

The Chair asked LD when the recent learning from other hospitals including Watford would begin to show in Trust performance. In response, LD commented that the Trust had begun a UEC reset and that so far March performance had already improved to 76% for four-hour waits, up from high-60s in January and February.

TM added that early decision-making and incorporating smart measures as a whole system approach would also support the decision making.

JD commented that work with ENH production system to ensure that as a Trust we are making the best during industrial action and learning from it showed which improvements could be replicated outside strike days.

The Chair said the Board looked forward to further improvements.

The Chair asked the Medical Director, JD to comment on the level of assurance that the Board could have as regards our ability to spot poor surgical outcomes considering national media coverage about poor surgical outcomes at other trusts. JD responded that the Trust monitored many sources of objective surgical data, including NHSI surgical outcomes, mortality data, learning from deaths reports, and NELA laparotomy audits. The Trust performed well in these areas. JD also mentioned that all moderate-harm and above incidents were reviewed daily. It was further noted that psychological safety was equally important as staff needed to feel that they were able to raise concerns openly. He remarked that staff often spoke more freely to him when he was wearing scrubs, which showed the importance of approachable leadership.

The Chair thanked JD.

The Board **RECEIVED** and **NOTED** the integrated performance report.

26/038 QUALITY AND SAFETY COMMITTEE (QSC) REPORT TO THE BOARD

The QSC Chair, DB highlighted the matters of concern to the Board. He commented that Martha's rule had been implemented well, but he was slightly worried demand could rise over time.

The QSC report to the Board was **NOTED.**

East and North Hertfordshire Teaching NHS Trust

26/038a

NHS CALL TO ACTION ANTIMICROBIAL (AMR)

The QSC Chair DB stated that AMR had increased since Covid. The Board was advised that around 60,000 people a year were affected nationally, and more than 2,000 died from resistant infections. DB emphasised the need for vigilance, because new antibiotics were not being developed quickly.

JD reassured the Board that our Trust was the best performer in the region at switching patients quickly from broad-spectrum to narrow-spectrum antibiotics. TM praised pharmacists for leading IV-to-oral switching. She suggested that the Trust should link with the Cambridge Infectious Diseases Network to explore innovation.

KMc asked about blood culture performance. JD answered that the change in laboratory provider had not affected performance, but clinicians needed to take larger blood samples.

DB commented that QSC will monitor this as business as usual.
The Chair agreed to the approach and that it could be done on a six-monthly basis.

Action: Include on the QSC annual cycle to monitor blood culture performance.

The Board **AGREED** to a **PARTIAL** assurance rating.

26/039 FINANCE PERFORMANCE AND PLANNING COMMITTEE (FPPC) REPORT TO THE BOARD

The FPPC Chair, RO highlighted matters of concern to the Board.

The FPPC report to the Board was **NOTED.**

26/039a

FPPC TERMS OF REFERENCE

The Board approved the committee's terms of reference, noting the Chief Executive's point about reviewing officer attendance.

The FPPC terms of reference was **APPROVED.**

26/040 PEOPLE AND CULTURE COMMITTEE (PCC) REPORT TO THE BOARD

The PCC Chair, JS drew attention to matters of concern to the Board.

The FPPC report to the Board was **NOTED**.

26/040a

PCC terms of reference

The PCC terms of reference was **APPROVED** subject to noting the Chief Executive's point about reviewing officer attendance.

East and North Hertfordshire Teaching NHS Trust

26/041 HEALTH CARE PARTNERSHIP (HCP) REPORT TO THE BOARD

The Chief Executive presented the report to the Board.
Audit and Risk Committee (ARC) Chair, KMc requested future discussion of HCP governance at ARC.

The HCP report to the Board was **NOTED**.

26/041a
ENH – HCP performance report
The ENH-HCP performance report was **NOTED**.

26/042 AUDIT AND RISK COMMITTEE (ARC) REPORT TO THE BOARD

The ARC Chair, KMc presented the committee report.

The ARC report to the Board was **NOTED**.

26/042a

The Audit and Risk Committee terms of reference

The Audit and Risk Committee terms of reference was **APPROVED.**

26/043 CHARITY TRUSTEE COMMITTEE (CTC) REPORT TO THE BOARD

The CTC Chair, NJ presented the committee report and informed the Board that:

- Sunshine Terrace redevelopment would begin this year.
- The charity would lead a £2m fundraising campaign for enhancements in the new paediatric unit.
- Non-executives and executives would be contacted to support the campaign.

The CTC report to the Board was **NOTED**.

26/044 DIGITAL COMMITTEE REPORT TO THE BOARD

The Digital Committee Chair, RO presented the report to the Board.

The Board was advised that the committee was transitioning from a OneEPR committee to a wider digital committee. It was also noted that OneEPR go-live was planned for November, but this depended on receiving high-quality software updates due 27 March and 13 April. Lastly that the digital outpatients work was progressing well but contact centre recruitment was a risk.
The Digital committee report to the Board was **NOTED**.

26/044a – Digital Committee terms of reference (ToR)

The terms of reference were approved, and the Board noted KMc's suggestion for layout consistency across all committee ToRs.

East and North Hertfordshire Teaching NHS Trust

Action: There should be layout consistency across all Committee ToRs.

The Digital Committee terms of reference was **APPROVED**.

26/045 ANNUAL CYCLE

The Board **RECEIVED** and **NOTED** the latest version of the annual cycle.

26/046 ANY OTHER BUSINESS

The Chair noted that this was Tichafara Phiri's final full Board meeting, as he would be leaving at the end of April. She thanked him for his contributions and perspectives.

There was no other business.

26/047 DATE OF NEXT MEETING

The date of the next meeting is 13 May 2026 to be held at Lister Hospital.

Ms Anita Day
Trust Chair
March 2026

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

Agenda item: 5

EAST AND NORTH HERTFORDSHIRE TEACHING NHS TRUST
TRUST BOARD ACTIONS LOG TO MARCH 2026

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
11 March 2026	26/038a	NHS call to action antimicrobial (AMR)	Include on the QSC annual cycle to monitor blood culture performance	This has been included on the QSC annual cycle	Deputy Trust Secretary	March 2026
11 March 2026	26/044a	Committee terms of reference (ToR)	There should be layout consistency across all Committee ToRs	This will form part of the Corporate governance team work cycle for 2026	Head of Corporate Governance	December 2026

East and North Hertfordshire Teaching NHS Trust

Chief Executive's Report

May 2026

Chief Executive Update

Trust Performance

As part of the NHS oversight framework segmentation and performance dashboard, the Quarter 3 acute trust league tables have been published. As has been the case every quarter since the league tables began, the Trust has been assessed as the highest rated trust in the East of England and 21st in the NHS overall.

Operations

February and March saw sustained high levels of activity across all hospital services.

In February, teams supported the birth of 334 babies, delivered care through nearly 55,000 outpatient appointments, and carried out almost 1,500 planned operations. Emergency services were particularly busy, with over 16,000 emergency attendances and 392 emergency operations, alongside more than 3,200 inpatient stays.

Activity levels increased further in March, demonstrating both rising demand and the scale of care being delivered. 370 babies were born, outpatient activity rose to more than 60,000 appointments, and 1,759 planned operations were completed. Emergency attendances exceeded 18,000, with 430 emergency operations, and inpatient stays increased to 3,742.

This month has seen the opening of the new Audiology Hub. This facility will allow us to see more patients in high quality diagnostic facilities that will both help reduce waiting times and deliver modern high-tech diagnostics.

Quality

We are committed to the continuous delivery of high quality services for our patients and fostering a culture of learning and improvement. In March, the trust successfully trained its first cohort of SWARM facilitators. SWARM is a rapid-response learning approach used to quickly bring teams together after an incident with potential or actual serious risk. It enables staff to reflect on what happened, share insights, and identify immediate learning to improve safety and quality of care.

Estates & Finance

The trust has secured more than £27 million in funding to improve its facilities, including a new £11 million children's care centre at the Lister Hospital in Stevenage. The new facility will bring together inpatient and outpatient children's services into a modern, purpose-built environment, improving patient experience and supporting safer, more efficient models of care.

In addition, the trust can now move forward with further improvements to its renal services, including upgrading facilities and developing its life-changing home dialysis service to benefit more patients.

Funding also allows for investment in the Lister Urgent Treatment Centre (UTC), ward refurbishment, replacement scanners and backlog maintenance. The new scanners include one MRI, two CT and an interventional radiology suite which uses image guidance for minimally invasive procedures.

Transformation

The trust is embarking on a new transformation programme. This aims to deliver a stepped change in optimising the use of our resources, in order to deliver shorter-waiting times, improve the quality of clinical care and patient experience and crucially to ensure we are able to do this within the resources we have available to us. Initial areas of focus include the urgent and emergency care pathway, theatres, outpatients, diagnostics and workforce utilisation. Underpinning all of this is a programme of 'brilliant basics' where we aim to ensure daily management is allowing the improvements we are striving for.

An important part of this is the application of our quality management system (ENHPS). Over recent weeks we have been approached by a number of trusts asking to arrange visits and understand more as they build their own quality management systems.

People

I am delighted to share that we are one of only a few trusts nationally to have more than one team selected as regional champions in the inaugural NHS Excellence Awards.

The Trust's Chemotherapy at Home programme and Jan-Axle Enabore for the trust's carers programme have been chosen as regional champions and shortlisted for the national awards, to be announced in June.

Congratulations to Princell Regis, who was awarded a Silver Award in the Vascular Access Nurse of the Year category at the British Journal of Nursing Awards, recognising excellence in vascular access care and the positive impact of the Trust's nurse-led MVCC service on patient safety and outcomes.

Jane Shaw, Patient Experience Project Co-ordinator, received a prestigious personal award from the High Sheriff of Hertfordshire in recognition of her exceptional work championing therapy animals across the trust. This award celebrates Jane's dedication and the wider contribution of the therapy dogs, ponies, their handlers and the Voluntary Services Team in enhancing patient experience and wellbeing.

And finally, in maternity services, colleagues were recognised at the East of England Perinatal Awards for innovative work that has delivered tangible improvements for women and families at the Lister Diamond Jubilee Maternity Unit. Paige McCretton, Lead Digital Midwife, presented the development of an innovative Telephone Triage e-learning package, now adopted nationally and endorsed by the Birmingham Symptom-specific Obstetric Triage System. Endorsed by the Birmingham Symptom-specific Obstetric Triage System, the Telephone Triage package can now be accessed by trusts across England, and with versions in development for Scotland and Wales. This represents a significant step forward in standardising triage education and supporting safer, more consistent maternity care.

Mary Goodin, Consultant Obstetrician, and Amanda Rowley, Director of Midwifery and Lead Divisional Director for the Women's & Children's Division, also presented learning from an induction of labour improvement workshop, which demonstrated marked improvements against baseline measures within 90 days and highlighted the power of collaborative, data driven improvement focused on service user experience.

And finally...

This is the final Chief Executive's Report that I will write as the trust's CEO before I leave to take up the same role at Mid and South Essex NHS Foundation Trust on 1 June.

This is not a decision I have taken lightly. Working in the trust has been one of the great privileges of my career. Over the past five years, I have been privileged to see the difference our staff's dedication has made – not just to our performance as a trust, but, far more importantly, to the patients and families who rely on us every day.

As I move to lead the organisation where my own friends and family receive our care, I will take huge inspiration and learning from those showing such dedication for the population of east and north Hertfordshire.

As the Board complete the important task of selecting my successor, I have utmost confident that Martin will do a fantastic job in leading a high-calibre executive team through this time of transition, with a strong focus on continued improvement for our patients.

I'm grateful to the Board, trust staff and local health and care partners for their significant support in what we have been able to achieve and positioning us so well for the future.

Adam Sewell-Jones
Chief Executive

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	9	
Report title	Whistleblowing Policy		**Meeting Date**	13 May 2026	
Author	Head of Employee Relations				
Responsible Director	Chief People Officer.				
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:

It is recommended that the Trust has a separate policy to cover whistleblowing, and to be clear what action must be taken and by who when a colleague raises concerns, in addition to providing clarity for those colleagues wishing to raise a concern.
This policy seeks to provide that clarity and confirm the protections afforded to those raising issues which would be considered whistleblowing.

Summary of key issues:

The Whistleblowing Policy is designed to encourage and enable employees, contractors, and stakeholders to raise genuine concerns about wrongdoing or malpractice within the organisation, in line with the Public Interest Disclosure Act 1998 (PIDA) and related UK legislation. The aim is to ensure concerns are raised and dealt with appropriately, without fear of reprisal

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**	☐

Having a clear policy available to all should enable better reporting of issues with a view to timely and appropriate resolutions, and mitigated risk.

Trust strategic objectives: *tick which, if any, strategic obective(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*

Report previously considered at & date(s):

NA

Recommendation	The Board is asked to confirm agreement to the Whistleblowing Policy

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Doc ID: TBC

East and North Hertfordshire Teaching NHS Trust

Public Interest Disclosure (Whistleblowing) Policy

About this document						
Version	001		Review Date			
Document Type *highlight selection	Guideline	**Policy**	Procedure	Protocol	SOP	Other *please specify
Usage & Applicability			*Trust Wide, all roles.*			
Division	Corporate		Speciality* (Unit if required)			People Directorate
Document Author	Head of Employee Relations					

Version Control

Version	Date	Summary of changes
001	DD//MM/YYYY	New document

Contents

1. Scope and Purpose

This policy is designed to encourage and enable employees, contractors, and stakeholders to raise genuine concerns about wrongdoing or malpractice within the organisation, in line with the Public Interest Disclosure Act 1998 (PIDA) and related UK legislation. The aim is to ensure concerns are raised and dealt with appropriately, without fear of reprisal.

This policy applies to all current and previous employees, agency staff, contractors, students on placement and volunteers who work for or with the organisation.

The law provides protection for employees who raise legitimate concerns about specified matters. These are called 'qualifying disclosures'. A 'qualifying disclosure' is one made in the public interest by the employee who has a reasonable belief that one of the following is being, has been, or is likely to be, committed.

- a criminal offence
- a miscarriage of justice
- an act creating risk to health and safety
- an act causing damage to the environment
- a breach of any legal obligation
- an act of sexual harassment
- concealment of any of the above

The trust will afford the protection from detriment offered within this policy to staff reporting harm or potential harm to patients however their concerns will not automatically be classified as whistleblowing unless within the above definition.

It is not necessary for the employee to have proof that such an act is being, has been, or is likely to be committed, reasonable belief is sufficient. The employee has no responsibility for investigating the matter; it is the employer's responsibility to investigate those.

Any employee who uses this policy and procedure will not be penalised for doing so. The employer will not tolerate harassment and/or victimisation of any employee raising concerns.

An employee who is not sure whether the conduct he/she is concerned about does constitute illegal or improper conduct or is unsure about how to proceed can contact their professional association/trade union, ACAS or Public Concern at Work, an independent charity who offer a confidential helpline.

2. Definitions

Acronym	Definition
PIDA	Public Interest Disclosure Act 1998
Whistleblowing	Known term to refer to disclosures made using the PIDA.
Public Interest	Concerns raised using this policy should be of a public nature not individual employment or work concerns which should be addressed using the grievance policy.

3. Roles & Responsibilities

Role	Duties
Chair and Non-Executive Directors	Provide oversight of public interest disclosures. Provide oversight of conflict of interest and appropriate risk management
Chief Executive	Will have overall responsibility for the application of this policy.
Board of Directors	Will receive regular reports to maintain oversight of concerns raised and how these are manged within the trust.

	Act as triage and signpost whistle-blowers to the correct procedure for support and investigation.
Chief People Officer	Has operational responsibility for ensuring that staff raising concerns are listened to and supported when raising a public interest disclosure.
People team	To support the CPO in the delivery of this policy Record all whistleblowing concerns on a case management system Provide reports to the Board and FOIA requests as requested Provide training for managers and staff on the application of this policy Signpost staff to the appropriate policy for their concerns Support investigations where other HR policies are utilised
Managers	To be aware of and adhere to the policy Signpost staff to the policy where they raise concerns of a PIDA nature
Employees	To raise concerns using the appropriate policy and seek advice as necessary.
Local Counter Fraud Specialist	To receive reports / referrals from the reporter, HR, Managers or CFO of concerns relating to potentially fraudulent behaviour. To liaise with the people team in employee related allegations To provide outcome reports to the CFO on all referrals

4. Policy and Procedure

4.1 Making a Disclosure to the Trust

Concerns may be raised verbally or in writing. Employees are encouraged to report to their line manager in the first instance. Where this is not appropriate, or the individual does not feel comfortable doing so they may make a disclosure to any of the following individuals: Medical Director, Chief Nurse, Chief People Officer, Chief Finance Officer, Senior Independent Director, the lead Non-Executive Director for freedom to speak up concerns or the Trust Board Chair. All disclosures should provide as much detail as possible, including relevant dates, names, and evidence.

Where the concerns raised identify a potential conflict of interest for the individual responsible for the investigation e.g. financial, health and safety or quality, the Chief People Officer will ensure the Chief Executive, Chair and lead non-executive director for freedom to speak up concerns are informed and safeguards are put in place to mitigate the risk to all parties.

4.2 Making a Disclosure to a prescribed body

We would encourage everyone to feel comfortable making a disclosure to the trust, however, if you do not feel able to you can make a disclosure to external designated bodies. A full list of whom can be found at Whistleblowing: list of prescribed people and bodies - GOV.UK

4.3 Procedure

1. Upon receiving a disclosure, the recipient will acknowledge receipt within five working days.
2. The recipient will discuss the matter with the appropriate lead (see flow charts in the appendices) and an initial assessment will be conducted to determine the appropriate course of action which may include referral to an external body such as the police, local counter fraud specialist or LADO.
3. Assess if the concern is covered by this policy
    - Is it a qualifying disclosure **and**
    - Is it in the public interest?

if the answer to either of these is 'no' then the matter is not a whistleblowing concern and should be managed using the most appropriate policy to address individual or collective workplace concerns. This may include but is not limited to the FTSU, grievance, health and safety, and anti-bribery and fraud policies (see appendix 3 for examples)

4. Where the concern is assessed and the outcome is there is no further action required / no case the answer the reporter will be notified of that outcome.
5. If deemed necessary, the concern will be referred for investigation under the most appropriate trust policy (e.g. grievance, disciplinary, health and safety, anti-fraud and bribery) ensuring confidentiality is maintained as far as possible.
6. If this is the outcome of the whistleblowing concern the reporter will be notified it is being referred for further investigation, kept up to date with progress and informed if their concern was substantiated or not.
7. Further information about the outcome will not be shared due to confidentiality of the individual being investigated.
8. There is not right of appeal against the outcome of a whistleblowing process.

4.4 Protection and Support

Whistleblowers acting in good faith and in the public interest, will not suffer any detriment, including dismissal, disciplinary action, or other unfavourable treatment, as a result of making a disclosure. Reporters are encouraged to report any unfavourable treatment to those named in section 4.1 and will be contacted 6 months after the case is closed to follow up on their experience during and after the process is concluded.

Any victimisation or retaliation against whistleblowers will be treated as gross misconduct and investigated as a disciplinary matter.

Support and advice will be made available to those raising concerns. Support can also be sought through independent organisations as follows:

1. Protect - Speak up stop harm - Whistleblowing Homepage
2. Employee Assistance Programme – 03303 800658 or vivup.co.uk
3. Your unions or professional body

4.5 Confidentiality and Anonymity

We prefer that you raise concerns openly so that we can better investigate and provide feedback, however, we recognise that you may be worried about repercussions. We will take all reasonable steps to protect the identity of whistleblowers with any breaches investigated and acted upon appropriately. However, in certain circumstances, it may be necessary to disclose their identity for legal reasons or to facilitate a thorough investigation. Whistleblowers will be informed before such disclosure occurs.

If you would prefer to raise a concern anonymously we will still record the disclosure and where it is deemed credible, take appropriate steps to investigate, however it may be harder to investigate if we cannot obtain further information. Please provide as much information as possible, including names, dates, and evidence, to enable a thorough investigation as further clarification will not be possible. Please also note that we are unable to provide feedback to anonymous concerns, however, the outcome will be recorded and reported alongside other whistleblowing matters.

4.6 Record keeping

Records of all whistleblowing concerns will be recorded on a case management system with the reason for the concern raised, name of the individual raising the concern and the outcome of the whistleblowing process (e.g. if it is referred to another trust process). Whistleblowing concerns will be recorded on the system as sensitive ensuring only those with the highest level of access within the people team will be able to see the names of the reporter. This system will be used to produce anonymised reports as required.

4.7 False or Malicious Allegations

While whistleblowers are protected when raising genuine public interest concerns, those raised for personal gain and/or deliberately false or malicious allegations may be treated as a disciplinary matter.

9. References & Associated Documents

Legislation and Guidance

Public Disclosure Act 1998
Employment Rights Act 2025
ACAS Guidance The law - Whistleblowing at work - Acas
DBIS Whistleblowing Guidance for Employers and Code of Practice March 2015

Trust Policies

Speaking Up Policy	CP304
Grievance Policy	HR14
Disciplinary Policy	HR10
MHPS	HR62
Anti-Fraud and Bribery Policy	CG004

10. Quality Indicators

Key Performance Indicators (KPIs) and metrics that measure adherence to policies and external regulations. Activity to monitor the use of this document is listed below

Policy Area/Objective	Monitoring Activity/Control	Key Performance Indictors (KPIs)	Frequency	Lead
Triangulate data from other sources (eg FTSU, complaints, EDI, mortality, etc) to identify, themes, patterns, hotspots, outcomes and systemic issues	Via the People Dashboard to the People & Culture Committee	Timescales for response / upheld concerns / malicious concerns /	Bi-monthly	CPO
Ensure shared learning across the trust from analysis of the above	Via Divisional Leadership Teams and Trust Management Group		Annually or as required	CPO

11. Impact and Accessibility

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.

Positively supporting individuals with a learning disability or Autism: All Trust policies and Standard Operating Procedures (SOPs) should include service arrangements relating to the provision of reasonable adjustments to support the care or management of service users who have an LD or Autism. These should be highlighted below, or where specific practices are used, included in the document content.

Protected characteristics impacted by this documented	Impact Type (Positive, Negative, or No Impact)	Reasoning & Mitigations
Age, sex, disability, Learning Disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity	No impact	Access to support is available to all irrespective of characteristics with additional support available via staff networks and Exec champions as required.

12. Dissemination and Access

This document is considered valid when viewed via ENHance or the staff intranet for East & North Hertfordshire 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 available on these platforms.

13. Document Governance

Document stakeholders involved in the creation/update and review of this document

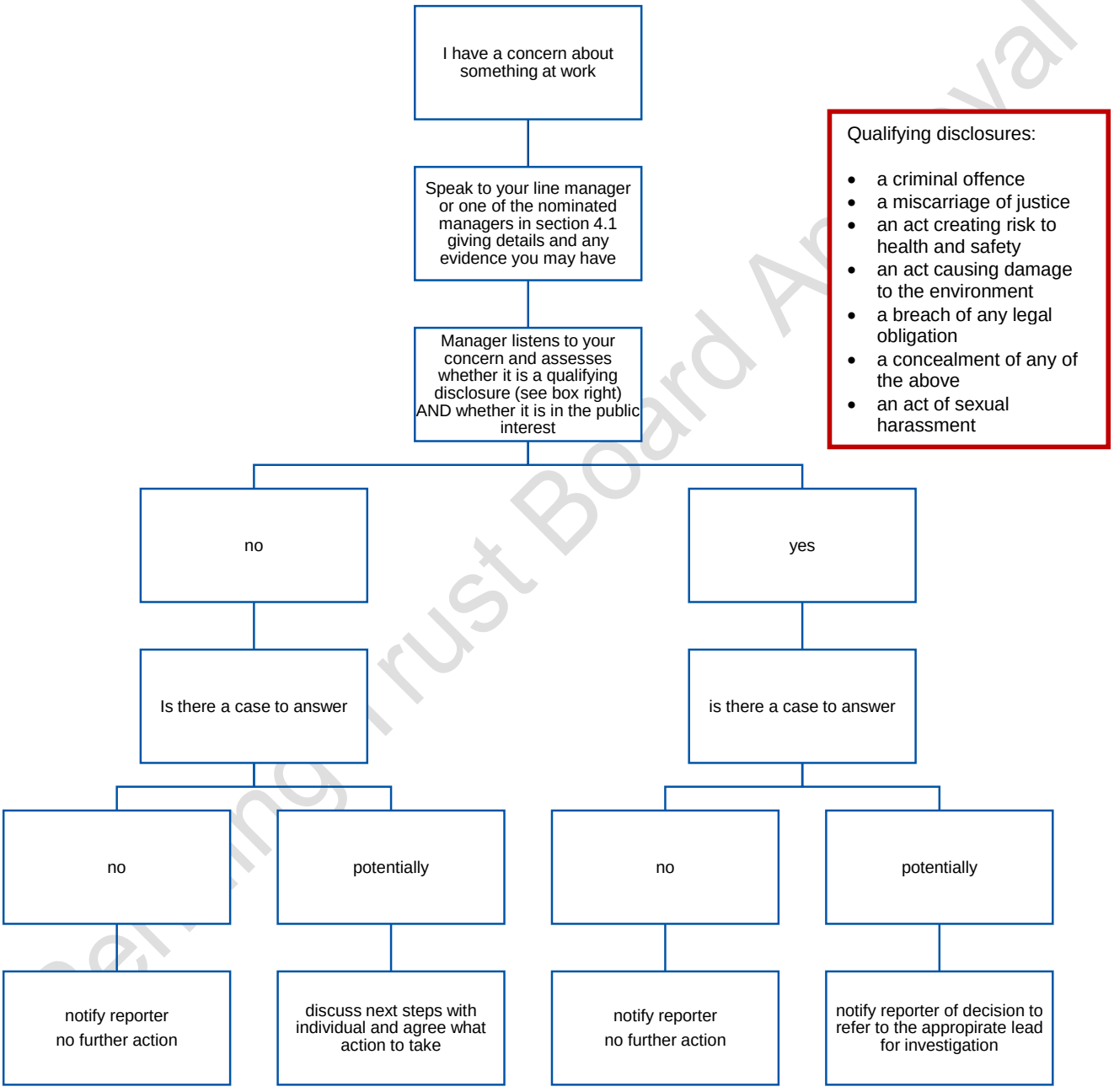
Document Stakeholder	Date Agreed	Contribution Type	Signature (People Team only)
Penny St Martin Chief People Officer		Approver	
Kim Hedley Staffside Chair		Co-chair	

Document Endorsement Record	
Meeting/Group/Committee Name	Date of meeting/approval
Trust Board	
People & Culture Committee	
Trust Partnership Forum	DD/MM/YYY

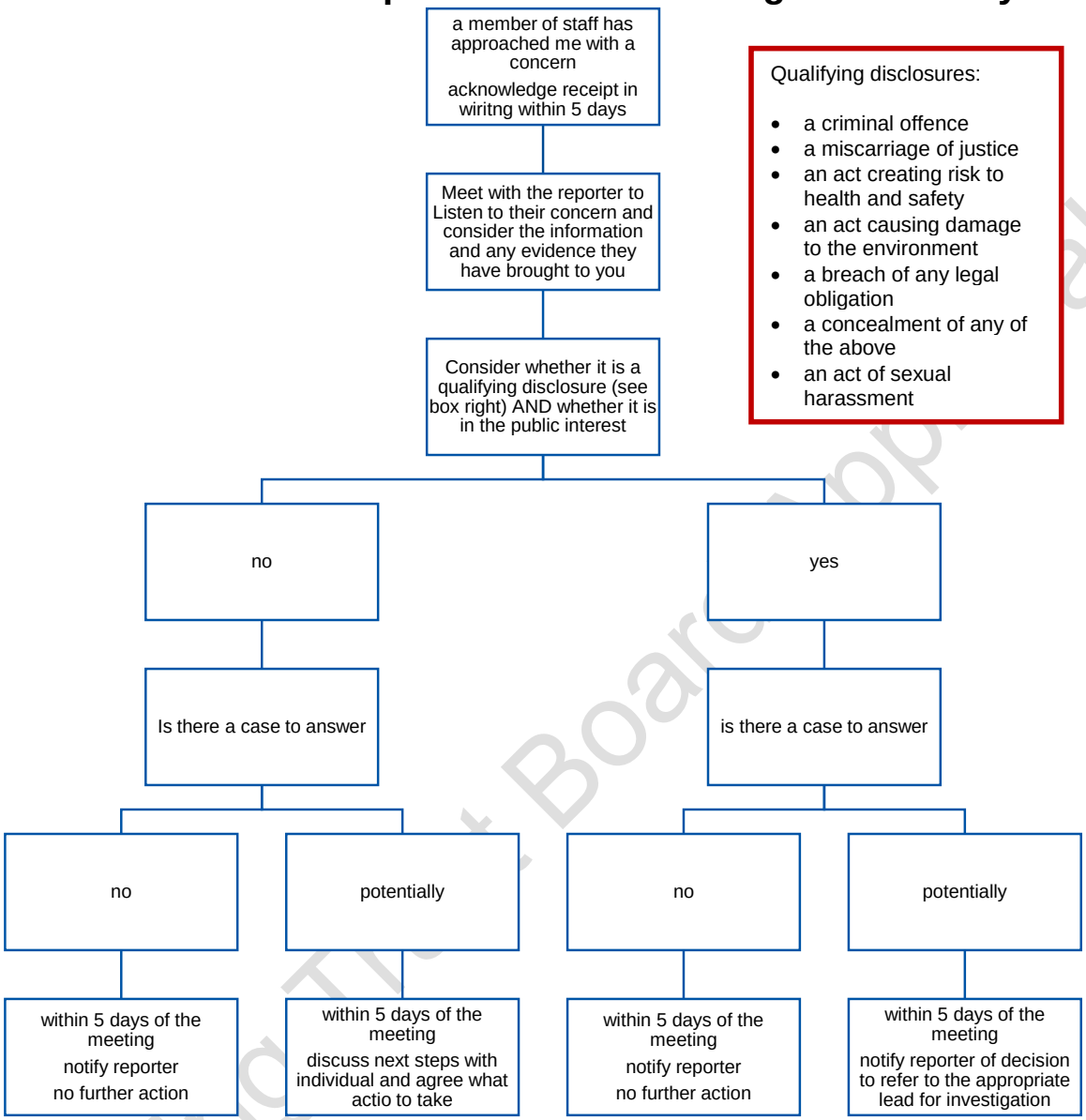
Admin use only	
Date of Endorsement at PCG* *(Policies only)*	DD/MM/YYYY
Governance checks completed	*Policy Officer*
Date Uploaded to ENHance and Trust intranet	DD/MM/YYYY
Legacy ID	N/A

10. Appendices

Appendix 1 Flowchart 1
How to report a Whistleblowing concern and what to expect



Appendix 2 Flowchart 2
What to do if someone reports a whistleblowing concern to you?



Recipient should

- Write to the reporter within 5 days acknowledging their concerns
- Meet with the reporter to establish the details and any evidence
- Discuss the concerns with the appropriate lead to assess whether it is a qualifying disclosure and if it is in the public interest
- Write to the reporter within 5 days of the meeting confirming the outcome of the assessment and the next steps
- Write to the appropriate lead referring the matter for investigation if required

Please note

It is not always possible to maintain your anonymity as in some situations an individual being investigated has the right to know who has raised the concerns against them. You will be informed if this is the case.

We will share the outcome of the whistleblowing concern however it may not be possible to share the outcome of another process with you as this may be confidential to the individual being investigated.

Appendix 3

Examples of concerns and where they would normally be considered (this is not an exhaustive list)

Theme	Whistleblowing	Freedom to Speak Up	Grievance	Health & Safety	Finance
Criminal Offence	Failure to safeguard multiple patients	Serious safeguarding concerns	I am not satisfied that my safeguarding concerns have been dealt with		Fraud and / or theft
Miscarriage of justice	Failure to investigate concerns correctly	Serious concerns about the way a process has been conducted	I am not satisfied with the outcome of my investigation.		
Health and Safety Risk	Multiple occasions of violence and aggression towards patients and staff by other patients.	Concerns about response to allegation of violence and aggression	I am not satisfied I am protected from violence and aggression towards me as an employee	There is insufficient protection for staff to monitor violence and aggression	
Damage to the environment	Greenwashing / misrepresenting trust environmental work / failure to manage waste correctly	Inappropriate use / disposal of chemicals	I am not satisfied with the response to my concerns		Failure of contractors to manage / correctly declare their environmental credentials
Breach of legal obligation	Failure to report to ICO disclosure of personal information for groups of staff or patients	Failure to maintain confidentiality of a patients information	Failure to maintain my confidential information	Failure to provide correct PPE	Failure to follow procurement or SFIs
Sexual Harassment (new 1 April 2026)	Member of staff targeting multiple patients or colleagues	Concern about individual one off behaviour towards a patient	Raising concern of sexual harassment towards themself by another person	We do not have sufficient protection to prevent sexual harassment or abuse in the trust (e.g. CCTV)	
Concealment of the above	Where by act or omission members of the trust have concealed any of the above types of concern	A manager or other has not dealt with a concern that effects patient care	My manager has not dealt with my concern about my health and safety at work		

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	10
Report title	Summary Learning from Deaths			**Meeting Date**	13 May 2026
Author	Mortality Improvement Lead				
Responsible Director	Medical Director				
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:

East and North Hertfordshire Teaching NHS Trust seeks to learn from every death that occurs.
This paper provides assurance to the Board that:

- Our rates of death remain lower than would be expected
- That we learn from scenarios when care does not meet the standard that we and our patients and carers set
- That we interrogate data to ensure we understand its meaning
- That we innovate to reduce mortality.

Summary of key issues:

Mortality improvement work is a continual on-going process within the Trust. This quarterly report provides a summary of the detailed Learning from Deaths report provided to the Quality and Safety Committee. That report outlines key results of this work, including the regular monitoring of mortality rates, together with outputs from our Q3 learning from deaths work. It also incorporates information and data mandated under the National Learning from Deaths Programme.

Prior to submission of the summary report to the board, the full report was approved by the Mortality Surveillance Committee and the Quality and Safety Committee, which agreed it appropriately highlighted current topics and activity of particular relevance in providing assurance to the Executive regarding this workstream.

Points of note this quarter include:

- Mortality rates remain stable and well positioned against national and Model Hospital Peer, with HSMR and SHMI in the 'as expected'/mid-range bands.
- No 3SD HSMR alerts; No 3SD SHMI alerts.
- Our neonatal service had indicated that extended perinatal mortality for 2025 may be above the national average when reported by MBRRACE in 2027. An in-depth review, including external peer review, has been undertaken to ensure robust learning and governance, the associated report will be presented to Mortality Surveillance Committee.
- Our maternity and neonatal service has also raised concerns regarding the lack of sound proofing to the bereavement room located on the Consultant Led Unit. It's close proximity to birthing rooms can be extremely distressing to families who have just experienced a loss. A request for improvement has been made to Estates and

Facilities.

- Initial consideration of how health inequality/deprivation data can be used in our learning from deaths work.
- Sustained increases in community deaths requiring scrutiny have continued to place stress on the Medical Examiner service, with concerns that the new funding regime, coupled with the Trust's current funding constraints, may represent a significant challenge to the service.
- Following Aqua's decision to decommission their online SJRPlus review tool at the end of March 2026, development of a mortality module on ENHance is underway, with a proposed 'go-live' date of May 2026.
- Learning from SJRs continues to be promoted by asking all clinical governance leads to ensure they are discussed at specialty Mortality and Morbidity meetings.
- To date one Q3 death receiving an SJR has been judged by the reviewer to have been more likely than not due to a problem in healthcare. The concern related to care in the community prior to admission rather than in-hospital care.
- To date six Q3 deaths receiving an SJR have been assessed as evidencing poor care – these have been escalated as patient safety incidents ensuring further review at specialty/division level.
- NELA (National Emergency Laparotomy Audit): while case ascertainment has improved, the lead is working with the Head of Coding and BI team to produce a script to identify cases to support sustained improvement.
- Cardiology basket alerts: while collaborative work between Coding and Cardiology remains ongoing, there are currently no cardiology basket HSMR/SHMI alerts.
- The Cardiology service has raised concerns regarding delays to TAVI CT which are being caused by current capacity issues in radiology. Focussed work is in progress to address these.

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**	☐

Ongoing focus on the areas detailed in this report are vital for the following reasons:

Equality:

- To constantly target health inequalities and involve patients in their care.
- To identify and reduce unwarranted variation through the creation of an environment of learning, autonomy, and accountability.

Patients' benefit/detriment:

- To continuously strive to improve services for the living by identifying good practice and suboptimal care in our reviews of those who have died in our care, both sharing this learning and using themes and trends identified to shape forward planning and quality improvement strategies.
- To promote seamless care for patients by identifying opportunities for more effective collaboration and co-ordination of services within the Trust and with our partners.

Legal/Regulatory:
To ensure compliance with the requirements stipulated in the National Guidance on Learning from Deaths (NQB 2017).

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*

Please refer to page 5 of the report.

Report previously considered at & date(s):

Mortality Surveillance Committee: 11 March 2026: Full report presented
Quality and Safety Committee: 25 March 2026: Full report presented.

Recommendation	The Board is invited to note the contents of this report.

To be trusted to provide consistently outstanding care and exemplary service

1. Executive Summary

1.1 Summary
Reducing mortality remains one of the Trust's key objectives. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust.

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

1.2 Impact
1.2.1 Strategic ambitions
The Trust has developed a framework of strategic objectives to support and drive continuous improvement. These are detailed on the front cover of this report. Additionally, a set of mortality focussed objectives has been developed to echo and support the overarching Trust's strategic ambitions. A new iteration of the strategy, developed to provide focus through 2025-27 was approved by the Mortality Surveillance Committee in June 2025.

1.2.2 Compliance with Learning from Deaths NQB Guidance
The national Learning from Deaths guidance states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This paper provides this information for Q3 2025-26. An in-depth Learning from Deaths Report covering the same period was provided to both the Quality & Safety Committee, and Mortality Surveillance Committee in March 2026.

1.2.3 Potential impact in all five CQC domains
At the heart of our learning from deaths work are the questions posed by the CQC's five domains of care, whether through the conduct of structured judgement reviews and clinical thematic reviews, through the monitoring and analysis of mortality metrics and alerts or invited service review. Whatever the approach taken, in all domains of care we seek to identify and reduce unwarranted variation in the care we provide and the associated outcomes for our patients.

Figure 1: Learning from deaths and CQC domains of care

1.3 Risks

The following represent areas identified where there is currently an element of concern. Two of these (ref 3398 and 3491) constitute a formal risk on the Trust's risk register.

Table 1: Current risks

Risks	Red/amber rating
SJRPlus review tool (1) Following transfer of the SJRPlus review tool from NHSE to Aqua, an element of risk has remained, as to date, Aqua has not conducted a pen test, on the basis that the App moved from one part of the Azure platform to another. Our Chief Information Officer approved our use of the tool, but with it being logged as a tolerated risk on the Risk Register. From the end of March 2026, the Aqua app will be decommissioned removing this risk.	Risk register ref: 3398
SJR review tool (2) A mortality module is being developed on ENHance to replace the Aqua App which is being decommissioned. As it has been necessary to fit in with the continuing roll-out of other ENHance modules, there will be a short gap between the closure of the Aqua App and go-live on ENHance. This will be in the region of 6-8 weeks. During this period deaths will continue to be monitored, and where any element of concern arises, cases will be raised as a patient safety incident to mitigate any risk and ensure appropriate learning.	
Extended neonatal mortality Our neonatal service gave an early indication that extended perinatal mortality for 2025 may be above the national average when reported by MBRRACE in 2027. An in-depth review, including external peer review has been undertaken to ensure robust learning and governance. Once this report has been presented to Mortality Surveillance Committee final detail will be provided in this report.	
Medical Examiner Service: Funding/capacity Changes to the way the service is funded from 2025-26, combined with the current funding constraints measures introduced at the Trust, have the potential to jeopardise the efficiency and effectiveness of the service. This would be to the detriment of bereaved families; the wellbeing of staff working within the service; our performance against mandated standards; and the Trust's reputation, especially with the Coroner Service. Additionally, it would put pressure on the mortuary.	
Cardiology: recurrent SHMI alerts to various elements of the cardiology basket of diagnosis groups Following recurrent mortality alerts across the cardiology diagnosis basket, and a report by the Cardiology Clinical Director, a joint initiative between Cardiology and Coding was implemented and remains ongoing. The latest update was at September Mortality Surveillance when it was agreed the collaborative work should continue with a further update in 12 months' time. Of note, there are currently no HSMR or SHMI alerts for any element of the cardiology basket of diagnosis groups.	

Cardiology: Delays to TAVI CT scans The service has raised a concern regarding current delays to TAVI CT caused by capacity issues in radiology. The issue was highlighted by a recent patient safety incident and focused work is in progress to improve the situation.	Risk register ref: 3491
Ovarian Cancer SACT 30 Day Mortality: External review findings In the 2017-20 national Systemic Anti-Cancer Therapy (SACT) audit, the Trust was identified as an outlier for 30 Day Mortality. Following discussion at Mortality Surveillance an external peer review was commissioned. This identified a lack of integrated care at MVCC. Following completion of the review of patient care, a formal SI report has been completed. A small number of associated actions remain outstanding. This risk will be maintained until these are confirmed as complete. This is now anticipated to be in late-2026.	

	Low risk		Medium risk		High risk

2. Context

Rich learning from deaths requires the triangulation of information from multiple sources, including mortality metrics, medical examiner scrutiny, structured judgement reviews, patient safety incident investigation outcomes, together with detail from other Trust quality and governance processes. This quarterly report provides a summary of key relevant activity, which has been reported in full to the Quality and Safety Committee.

2.1 Headline mortality metrics

Table 2 below provides headline information on the Trust's current mortality performance.

Table 2: Key mortality metrics

Metric	Headline detail
Crude mortality	Crude mortality is 0.93% for the 12-month period to Nov 2025 compared to 0.96% for the latest 3 years.
HSMR: (data period Dec24 – Nov25)	HSMR for the 12-month period is **88.85, *'Mid-range'*.**
SHMI: (data period Sep24 – Aug25)	SHMI for the 12-month period is **92.09, 'as expected' band 2.**
HSMR – Peer comparison	ENHT ranked 4th (of 10) within the Model Hospital list* of peers.

* We are comparing our performance against the recommended peer group indicated for ENHT in the Model Hospital (updated in November 2022).

Figure 2 below shows the Trust's latest in-month and rolling 12-month trend for the three key mortality metrics: Crude mortality, HSMR and SHMI, as reported by CHKS. Following a prolonged downward trend since March 2023, rolling 12-month HSMR plateaued, then has shown slight increases over the last 8 months.

Rolling 12-month SHMI reported by CHKS stands at **92.09** to Aug 2025.This represents a slight increase from the last reported **91.44** for the12 months to May 2025.

Figure 2: Trust key mortality metrics: Latest position

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
HSMR - Monthly	102.0	83.6	89.4	82.1	84.9	92.7	91.5	106.4	82.7	78.8	78.7	91.9
HSMR - Rolling Month	86.6	86.1	87.4	86.9	87.8	87.7	88.8	89.5	89.4	89.0	88.2	88.9
SHMI - Monthly	95.6	92.1	105.1	103.2	89.1	103.8	90.4	99.0	83.3			
SHMI - Rolling Month	89.2	89.1	91.2	91.9	91.5	91.8	92.2	92.5	92.1			
Mortality Rate - Monthly	1.29	0.97	1.05	0.92	0.94	0.96	0.80	0.83	0.76	0.70	0.90	0.94
Mortality Rate - Rolling Month	0.88	0.86	0.88	0.87	0.89	0.89	0.90	0.91	0.90	0.90	0.90	0.92

2.2 Mortality alerts

2.2.1 CQC CUSUM alerts

There have been no CQC alerts in Q3.

2.2.2 HSMR CUSUM alerts

There are no HSMR CUSUM red alerts which constituted a rolling 12-month 3 standard deviation outlier, for the year to Nov 2025.

2.2.3 SHMI CUSUM alerts

CHKS also reported no SHMI CUSUM red alerts constituting a rolling 12-month 3 standard deviation outlier for the latest period to Aug 2025.

2.2.4 Other external alerts

There are no current active external alerts.

2.3 Health inequalities and deprivation

The reduction of health inequalities is a stated priority in the latest NHSE priorities and operational guidance, both for ICBs and acute providers. Trusts are urged to consider health inequalities in their assessments of quality in an attempt to ensure fair access, outcomes, and experiences across all sectors of the population. Health inequalities are seen as avoidable, systemic injustices that lead to poorer health, increased costs, and lost productivity.

While the subject of health inequalities is relevant across the whole spectrum of our care for patients, we are keen to start to consider it from the perspective of our learning from deaths work.

SHMI Contextual Indicator for deprivation

The SHMI methodology does not make an adjustment for deprivation. This is because adjusting for deprivation might create the impression that a higher death rate for those who are more deprived is acceptable.

However, deprivation is the subject of one of its Contextual Indicators, designed to accompany the core SHMI publication, providing additional information about the context in which a hospital operates, helping to understand SHMI results. Patient records are assigned to one of five deprivation groups (quintiles) using the Index of Multiple Deprivation (IMD).

We are now routinely monitoring this indicator. To date this has shown that our Trust has a significantly higher percentage of activity relating to those in quintile 5 (least deprived) and significantly less activity relating to those in quintile 1 (most deprived) than the national average and that this is mirrored by the percentage of deaths in those quintiles.

We are working with our business intelligence colleagues to improve the accessibility of this deprivation information, with the aim of routinely including deaths of patients from lower quintiles in deaths selected for structured judgement review.

While we have recognised that in comparison to the national picture, we have relatively low levels of deprivation in our geographical area, this will enable us to identify specific learning or themes that may help us to address potential health inequalities for this small, but vulnerable cohort of patients in our locale.

2.4 Key Learning from Deaths Data

2.4.1 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below for Q3 2025-26.

Table 3: Q3 2025-26: Learning from deaths data

	Oct	Nov	Dec
Total in-hospital deaths (ED & inpatient)	124	119	127
SJRs completed on in-month deaths (at 23.01.26)	32	26	7
Patient safety incident escalation from SJR (by month of death) (at 23.01.26)	13	9	3
SJR outcome: Deaths more likely than not due to problem in care (≥50%) (at 23.01.26)*	1	0	0
Learning disability deaths	1	0	1
Mental illness deaths	2	0	2
Stillbirths	0	2	0
Child deaths (including neonates/CED**) ***	2	0	0
Maternity deaths	0	0	0
PSIIs reported regarding deceased patient	1	0	0
PSIIs approved regarding deceased patient****	0	3	0
Complaints received in month regarding deceased patient	2	6	1
Requests received in month for a Report to the Coroner	11	7	6
Inquests attended	2	2	6
Regulation 28 (Prevention of Future Deaths)	0	0	0

Notes:

* *In this case the concerns related to care provided prior to admission. The concerns related to Catheter Care in the community (Perforated bladder due incorrectly sited catheter), the concerns were shared with HCT who are investigating. The reviewer did not consider that the care provided in-hospital by the Trust contributed to the outcome.*

***Medical termination of pregnancies where the baby is born with signs of life are not included in these figures. Pre-term non-viable births early neonatal deaths (born at ≤ 22 weeks) are also not included. Early neonatal deaths born after 22 weeks are included.*

****The number of child/neonatal deaths reported in the table above relate to deaths which occurred in-hospital, which aligns with the 2017 Learning from Deaths guidance.*

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

2.4.2 Learning from deaths dashboard

The National Quality Board provided a suggested dashboard for the reporting of core mandated information. This dashboard is provided at Appendix 1.

3.0 Scrutiny to SJR

3.1 Medical Examiner Scrutiny

Table 4: Medical Examiner scrutiny data: Q3 2025-26

Scrutiny detail	Oct	Nov	Dec	Q3 Total
Total in-hospital deaths (excluding MVCC)*	125	119	127	371
ENHT deaths scrutinised by ME	125	119	127	371
MCCDs not completed within 3 calendar days of death	19	6	21	46
ME referrals to Coroner	22	19	20	51
Deaths where significant concern re quality of care raised by bereaved families/carers	0	2	2	4
Patient safety incidents notified by ME office following scrutiny	2	2	1	5
ME referrals for SJR	18	16	10	44
Community deaths reviewed	237	246	251	734
Deaths referred by the Coroner to ME office to review	19	23	33	75
Total deaths reviewed				1180

Notes:

* *MVCC deaths are excluded as these deaths are not scrutinised by our Trust, they are instead scrutinised by Hillingdon.*

3.2 Structured Judgement Reviews

3.2.1 SJR and deaths YTD headline data

Table 5: Headline 2025-26 Q1-3 SJR and deaths data

Data count	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1-3 Total
Total in-patient deaths	109	116	96	106	88	84	115	112	120	946
Total ED deaths	8	6	8	3	8	8	9	7	7	64
SJRs completed on in-month deaths (at 23.01.2026)	30	29	41	47	36	40	32	26	7	288

The above table shows that by 23 January 2026, 29% of 2025-26 hospital deaths have received a formal structured judgement review. This is currently above our internal target of 25%.

3.2.2 Learning beyond SJR

3.2.2.1 SJR patient safety incident escalations

Table 6: Year to end of Q3 Patient Safety Incidents reported following SJR

Escalations for deaths in month (at 23.01.2026)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Patient Safety Incident Escalations from SJRs	10	5	8	9	8	9	13	9	3	74

For deaths in the current year which have been subject to an SJR, 74 cases have been escalated as a patient safety incident.

Learning from concluded patient safety incident investigations relating to deaths will be collated and added to themes and trends identified in SJRs to inform future quality and

improvement work. This quarterly report will detail outcomes of incidents escalated from SJRs where the reviewer judged the death to be more than 50:50 likely preventable and/or the quality of care to have been very poor. Additionally, incidents relating to deaths which are subject to PSII under PSIRF will be included, which will often not have received an SJR. The report will cover cases concluded in the current quarter, irrespective of the date of death of the patient.

In Q3, five cases matching these criteria were concluded and discussed at Mortality Surveillance.

Table 7: Q3 2025-26: Concluded Escalated Cases Summary

SJR/ SI/PSII	Death Preventability (Final MSC decision)	Incident category	Learning themes
SJR	Possibly preventable less than 50:50	Delay in receiving treatment/care	Treatment/Management Plan
PSII	Strong evidence of preventability	Hospital Infection	Fundamentals of Care
SJR	Possibly preventable less than 50-50	Failure to Follow Policy	Treatment/Management Plan, Clinical Monitoring/Obs/planning, Communication with patient, relatives and carers
SJR	Possibly preventable less than 50-50	Delay in receiving treatment/care	Medication/IV fluids/Electrolytes/Oxygen, Communication
PSII	Definitely preventable	Medication Error	Medication/IV fluids/Electrolytes/Oxygen, Documentation

The two deaths judged to have been more likely than not due to a problem in healthcare have been through the rigours of a PSII, with attendant remedial action plans aimed at learning and guarding against the potential for future reoccurrence.

3.2.3. Learning and themes from concluded mortality reviews
A quarterly ‘Food for Thought’ presentation is created, each iteration focusing on a particular aspect of SJR outputs. These presentations are shared in forums such as Mortality Surveillance Committee, Divisional Quality & Safety meetings and with the ICB. A condensed version of these presentations is now also shared in QISS documentation packs.

From February 2025 Clinical Governance Leads have also been asked to ensure that all SJRs are discussed in their specialty Mortality & Morbidity meetings, or other appropriate governance forums.

4.0 Improvement activity

Table 8: Focus Areas for Improvement

Diagnosis group	Summary update
Ovarian Cancer	In the 2017-20 national Systemic Anti-Cancer Therapy (SACT) audit, the Trust was identified as an outlier for 30 Day Mortality. The subsequently commissioned external peer review identified a lack of integrated care at MVCC. Following completion of the review of patient care, a formal SI report was completed. A small number of associated actions remain outstanding. This risk will be maintained until these are confirmed as complete. Revised anticipated completion is September 2026.
Cardiology	Following recurrent mortality alerts across the cardiology diagnosis basket, and a report by the Cardiology Clinical Director, a joint initiative between Cardiology and Coding was

diagnoses	implemented and remains ongoing. The latest update was at September Mortality Surveillance when it was agreed the collaborative work should continue with a further update in 12 months' time. Of note, there are currently no HSMR or SHMI alerts for any element of the cardiology basket of diagnosis groups. To date no concerns have been raised regarding the quality of care.
Sepsis	While HSMR performance relative to national peer remains extremely well placed, achievement of sepsis targets remains variable. The sepsis team continues to develop multiple initiatives aimed at improving compliance.
Stroke	The latest published SSNAP report covered the period July-Sept 2025. The Trust's overall rating had gone from an E to a D with improvements in 7 of the domains. Our overall score (rounded up) improved from 38 to 44. There is a multidisciplinary team which continues to work on all aspects of performance which is reflected in the service's overall action plan and is discussed at their regular performance meetings.
Emergency Laparotomy	In the 2019 National Laparotomy Audit Report, the Trust's risk adjusted mortality for emergency laparotomy stood at 13%, with the Trust ranked in the bottom 20% of reporting Trusts nationally. Since this time the NELA service has worked tirelessly to improve performance. In collaboration with Coding/Business Intelligence the service is working to create a script to identify all NELA cases. This should significantly increase case ascertainment. In the meantime, a focus on manually checking theatre activity has already resulted in a significant improvement to case ascertainment, which is currently close to 100%. • Once the case ascertainment script is functioning, work with the BI team is proposed to enable more real time access to data • Significant improvement to the service by virtue of 80% of NELA patients now being seen by a consultant geriatrician • Strategic focus is maintained via a regular NELA meetings. The current focus is on time from front door to theatre, including ED assessment and CT scan • Establishing a dedicated radiology request on ICE for NELA CT remains a challenge.

5.0 Preventable deaths

Here we are referring to those deaths that have been judged more likely than not to have been preventable on the basis of an SJR. It must be remembered that the question of the preventability of a death is the subjective assessment of an individual reviewer on the basis of a SJR desktop review. While not definitive, the assessment by them that the death was more likely than not due to a problem in healthcare (more than 50:50% preventable) provides an invaluable, powerful indication that further in-depth investigation of the case is required using the Trust's Patient Safety Incident processes.

The table below provides year to end of Q3 deaths/SJR/Preventability data (detailing SJRs conducted up to 23 January 2026). The outcome of investigations and actions relating to deaths judged more than 50:50 preventable are discussed by the Mortality Surveillance Committee.

As stated above, the preventability of death data provided in this report is taken from mortality reviewers assessment in their structured judgement reviews. Where cases are escalated for further patient safety review/investigation, the additional rigour employed may bring to light detail which results in a downgrading (or increase) to the level of harm deemed to have been caused. The results of these more in-depth reviews are used when estimating

the number of deaths judged to be more likely than not due to a problem in healthcare reported in the annual Quality Account.

Table 9: 2025-26 SJR preventable deaths data Year to the end of Q3

Data count (at 23.01.2026)	**Apr**	May	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
Hospital deaths (ED & inpatient)	117	122	104	109	96	92	124	119	127	1009
SJRs completed on in-month deaths	30	29	41	47	36	40	32	26	7	288
% of deaths subject to SJR to date	26%	24%	39%	43%	38%	43%	26%	22%	6%	29%
Deaths judged more likely than not to be due to a problem in healthcare	0	1*	0	1	0	1	1**	0	0	4
% SJRs assessed ≥50:50 preventable	0%	3%	0%	2%	0%	2.5%	3%	0%	0%	1%

**In this case the concerns related to care provided prior to admission. The patient had been discharged from PAH with 1 week supply of anticoagulants with instruction for repeat prescription by GP. This did not happen. The reviewer did not consider that the care provided in-hospital by the Trust contributed to the outcome.*

*** In this case the concerns related to care provided prior to admission. The concerns related to Catheter Care in the community (Perforated bladder due incorrectly sited catheter), the concerns were shared with HCT who are investigating. The reviewer did not consider that the care provided in-hospital by the Trust contributed to the outcome.*

6.0 Options/recommendations

The Board is invited to note the contents of this Report.

Appendix 1: Learning from Deaths Dashboard

East and North Hertfordshire Trust: Learning from Deaths Dashboard - December 2025-26

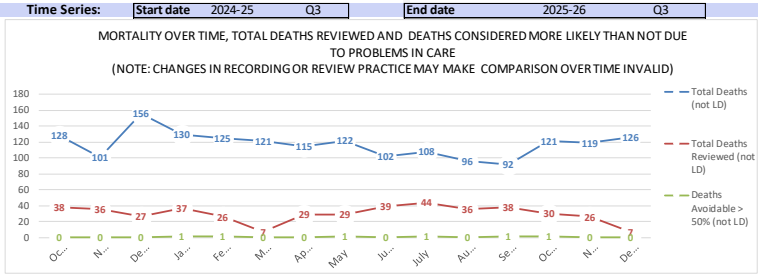
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology (SJRPlus)

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
126	119	7	26	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
366	296	63	118	1	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1001	1376	278	293	4	5

Time Series: Start date 2024-25 Q3 — End date 2025-26 Q3



Total Deaths Reviewed, categorised by PRISM Score/SJRPlus preventability score

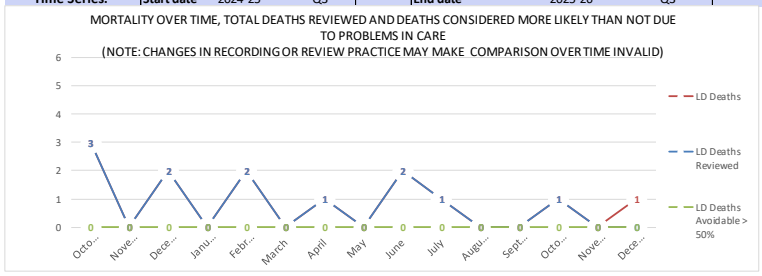
Score 1 Definitely preventable			Score 2 Strong evidence of preventability			Score 3 Probablypreventable (more than 50:50)			Score 4 Probably preventable but not very likely			Score 5 Slight evidence of preventability			Score 6 Definitely not preventable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	14.3%	This Month	6	85.7%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	1.6%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	1.6%	This Quarter (QTD)	10	15.6%	This Quarter (QTD	52	81.3%
This Year (YTD)	0	0.0%	This Year (YTD)	1	0.4%	This Year (YTD)	3	1.1%	This Year (YTD)	7	2.5%	This Year (YTD)	28	10.0%	This Year (YTD)	241	86.1%

Summary of total number of learning disability deaths and total number reviewed using the SJR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	1	1	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
6	11	5	10	0	0

Time Series: Start date 2024-25 Q3 — End date 2025-26 Q3



Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	11	
Report title	Annual review of Standing Orders, Scheme of Reservation and Delegation & Standing Financial Instructions		**Meeting Date**	13 May 2026	
Author	Financial Controller				
Responsible Director	Deputy CEO and Chief Finance Officer				
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 updates the delegated financial limits set out in Appendix 2B, specifically those relating to purchasing controls within the Trust (see page 95).

In addition, a correction has been made on page 28, where reference to the "One EPR Committee" has been amended to the correct committee name, the Digital Committee.

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 SOs, SoRD and SFIs form part of the Trust's statutory governance framework and are required under the NHS Act 2006. Maintaining an up-to-date and compliant framework is essential to ensure lawful decision-making, appropriate delegation of authority, and effective financial control.

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*

Failure to maintain an up-to-date governance framework may result in non-compliance with statutory requirements, unclear delegation of authority, and increased risk of control weaknesses.
This review mitigates those risks by ensuring clarity and alignment with current organisational and legislative requirements.

Report previously considered at & date(s):

Audit and Risk Committee – 14 January 2025 (endorsement of previous version)
Trust Board – 30 June 2025 (endorsement of previous version)
Audit and Risk Committee – 31 March 2026

Recommendation	The Board is asked to endorse the updated version.

To be trusted to provide consistently outstanding care and exemplary service

DOC ID: Insert DOC ID

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~~16
Full review due before	31 March 2027
Document type	Constitutional Policy
Version type	~~Version: 15~~Version: 16
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 1~~5~~4, approved by the Board in ~~May 2023~~June 2025.
- Changes to the limits within the Scheme of Reservation and Delegation (SoRD) have been introduced to strengthen financial control, oversight and decision-making governance.
- ~~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.~~

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

Contents

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

	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

	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

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	

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.

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

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 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.

The Trust shall have not more than 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).

2.2. 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.

2.3. 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.

2.4. Appointment and Powers of Vice-Chair

(1) Subject to Standing Order 2.4 (2) below, the Chair and members of the Trust may appoint one of their numbers, who is not also an officer member, to be Vice-Chair, for such period, not exceeding the remainder of his term as a member of the Trust, as they may specify on appointing him.

(2) Any member so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Vice-Chair in accordance with the provisions of Standing Order 2.4 (1).

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

2.5. Joint Members

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.

2.6. Patient and Public Involvement

The Trust works with the local involvement network 'Healthwatch'. Healthwatch England was set up to make sure the views and experiences of consumers across

the country are heard clearly by those who plan and run health and social care services and they are supported by legislation and a partner of the Care Quality Commission. Each local Healthwatch is part of its local community and works in partnership with other local organisations.

2.7. Role of Members

The Board will function as a corporate decision-making body, Officer and Non-Officer Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) **Executive Members**

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

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.

The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner

with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.8. Corporate Role of the Board

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

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

(3) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 3. 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.

2.9. 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.

2.10. 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.

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 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.

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;
- 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 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.

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 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

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

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.

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.

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.

v) ~~OneEPR~~ Digital Committee

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

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

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 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

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

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

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.

Knowingly providing false information, or knowingly failing to disclose information, may constitute offences under the Fraud Act 2006, which could result in disciplinary action and/or criminal or civil action being taken. Any suspicions of fraud, bribery or corruption must be reported to the Trust's Local Counter Fraud Specialist (LCFS)/Anti-Crime Specialist (ACS).

7.1.4. **Recording of Interests in Trust Board minutes**
At the time Board members' interests are declared, they should be recorded in the Trust Board minutes.

Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5. **Publication of declared interests in Annual Report**
Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6. **Conflicts of interest which arise during the course of a meeting**
During the course of a Trust Board or Board Committee meeting, if a conflict of interest is established, the Board member concerned or any other attendee should declare their interest and should withdraw from the relevant part of the meeting and play no part in the relevant discussion or decision or only participate with the full knowledge and agreement of the Committee members. (See overlap with SO 7.3).

7.2. Register of Interests

7.2.1. The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared by both executive and non-executive Trust Board members.

7.2.2. These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3. The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.3. Exclusion of Chair and Members in proceedings on account of pecuniary interest

7.3.1. **Definition of terms used in interpreting 'Pecuniary' interest**
For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

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

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

iii) "Pecuniary interest"

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

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

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

iv) Exception to Pecuniary interests

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

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

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

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

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

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

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

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

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

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

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

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

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)

- 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.

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.

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.

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.

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	

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

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	

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
3. Annual Reports, Accounts and Audit (continued)	3.5	Approve 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	

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: - 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	

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	5.3	Approval of clinical, quality & safety policies including: - 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 .		Quality & Safety Committee	
	5.4	People and workforce (HR) policies.		Chief People Officer with Staffside Chair	
	5.5	Any policies not expressly reserved or delegated are delegated to the Chief Executive, who may delegate to a specified officer.		Chief Executive	
	5.6	Change to Policies so adopted shall be listed and held by the senior officer responsible for policy management.		Chief Nurse	
6. Strategy, Plans and Budgets	6.1	Define the strategic aims and objectives of the Trust.	✓		
	6.2	Approve annual financial plan.	✓		
	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.	✓		

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	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)	✓		
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.	✓		
	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	

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	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	
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.	✓		
	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)	

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	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	

Appendix 2 – Standing Financial Instructions

1. Introduction

1.1. General

1.1.1. These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Secretary of State under the provisions of the National Health Service Act 2006 (as amended),for the regulation of the conduct of the Trust in relation to all financial matters.. They have effect as part of 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 its financial transactions are carried out in accordance with the law and 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 apply to everyone working for the Trust. 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. 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**

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;

(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), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

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

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

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

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

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

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

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) 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.

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.

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

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) 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 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 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.

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 limit control

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

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 Secretary of State.

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

4.1. Preparation and Approval of Plant and Budgets

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

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

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

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 annual plan;

(b) accord with workload and manpower plans;

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

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

(e) identify potential risks.

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

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

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

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.

4.2. Budgetary Delegation

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.

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

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.

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.

4.3. Budgetary Control and Reporting

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;

(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.

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.

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.

4.4. Capital Expenditure

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).

4.5. Monitoring Returns

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

5. Annual Accounts and Reports

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 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.

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.

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 Group Accounting Manual.

6. Bank and Government Banking Service (GBS) Accounts

6.1. General

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 issued from time to time by the Department of Health and Social Care. In line with 'Managing Public Money' published by HM Treasury, Trusts should minimise the use of commercial bank accounts and only consider the use of them if the required services are not provided by the Government Banking Service.

6.1.2. The Board shall approve the banking arrangements.

6.2. Bank and GBS Accounts

6.2.1. The Director of Finance is responsible for:

(a) Establishing bank accounts operated via the Government Banking Service;

(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.

6.3. Banking Procedures

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.

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.

6.4. Tendering and Review

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.

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.

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

7.1. Income Systems

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.

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

7.2. Fees and Charges

7.2.1. The Trust shall comply with Department of Health and Social Care's 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 in setting prices for other NHS service agreements.

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.

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.

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.

7.3. Debt Recovery

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

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

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

7.4. Security of Cash, Cheques and other Negotiable Instruments

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 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.

8. Tendering and Contracting Procedure

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.

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).

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.

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.

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 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.

8.6. Formal Competitive Tendering

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

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.

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);

(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.

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.

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.

8.7. Contracting/Tendering Procedure

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.

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.

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.

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).

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.

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.

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.

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.

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.

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.

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

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

8.8. Quotations: Competitive and Non-Competitive

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.

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.

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.

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.

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.

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.

(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.

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.

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.

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.

8.15. In-house Services

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.

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.

(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.

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.

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

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

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.

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

9.1. Service Level Agreements (SLAs)

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 Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

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

9.3. Commissioning

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 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.

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.

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 FRC guidance on Board Effectiveness (updated 2018).)

10.1.2. The Committee will make 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 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.

10.1.4. 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 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;

(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;

(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:

- 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) 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;

(b) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Procurement Rules where the contract is above a stipulated financial threshold);

(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;

(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 Public Procurement 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 Conflicts of Interest Policy and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff");

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash and any other specific areas agreed by the Director of Finance

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of employees and officers authorised to certify invoices are notified to the Director of Finance;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

(l) petty cash records are maintained in a form as determined by the Director of Finance.

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.

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 NHSE 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 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;

(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 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.

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

15.1.4 Business cases presented to FPPC and 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 Investment Group (led by the Deputy Director of Finance) collate capital requests from all Divisions. The applications are considered for inclusion within the Annual Capital Programme. A schedule of approved bids will be prepared for review at the 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.

15.1.6 On an annual basis, the 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 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 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 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.

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

15.1.14 Where capital schemes are in excess of the Trust's delegated limits, they will require NHSE approval.

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

15.2.1 When the Trust proposes to use finance which is to be provided other than through its allocations, the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health 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 authorised 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..

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.

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 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.

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 Estates 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.

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 Head of Department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud, bribery and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant LCFS who will decide, in consultation with the Director of Finance. 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.

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 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;

(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 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:

(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.

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; Conflicts of Interest Policy. This policy follows the national guidance on Managing Conflicts of Interest in the NHS and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

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 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 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).

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.

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	

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	

		Chief People Officer for HR SLAs	
	Between £10,001pa and £1,000,000	Deputy Director of Finance and Corporate Lead e.g. Estates, Finance, HR	
	Up to £10,000pa	Assistant or Associate Director of Finance and Corporate Lead e.g. Estates, Finance, HR	

*Note – any agreement in excess of three years will require Director of Finance sign-off

Contracts for the provision of Goods and Services (not included within a Service Level Agreement above) and Other Revenue Expenditure

Once the underlying contract has been approved, using the delegated limits below, the receipt of goods and services and payment of 'Non-PO' invoices can be based on the periodic payments i.e. monthly or quarterly invoices. Purchase Orders includes those raised through Oracle, , 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

	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~~	~~Changed~~
	~~Over £250,001 and up to £750,000~~	~~Director of Finance~~	
	~~Up to £250,000~~	~~Voting Executive Director~~	
	£100,001 +	Deputy Chief Executive / Director of Finance	Changed
	Up to £100,000	Deputy Director of Finance, ~~Finance and non-~~Other voting Executive Directors	Changed
	Up to £50,000	~~Divisional Leadership Team~~Other Executive Directors (non-voting)	Changed
	Up to £25,000	Divisional Leadership Team~~Tier one – Heads of Department / Deputy Directors~~	Changed
	Up to £5,000	Tier one – Heads of Department / Deputy	Changed

		DirectorsTier two – Service Managers / Matrons / Other Clinical Directors	
	Up to £1,000	Tier three – other budget managers not picked up above	Changed
Pharmaceuticals	Any value	Director of Finance, Director of Operations	Unchanged
	Up to £50,000	Head Pharmacist	Unchanged

2. **Invoices excepted from the Purchase Order Process**

Type	Amount	Authorised Officer	Current Approver
All payment types below	Over £250,000	Director of Finance	Unchanged
Utilities (Phones, Electric, Gas, Water, Waste Collections)	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged
	Up to £50,000	Head of relevant area (IT, Estates)	Unchanged
Rates	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged
	Up to £50,000	Director of Estates	Unchanged
Lease car invoices	Over £5,001 and up to £250,000	Deputy Director of Finance	Unchanged
	Up to £5,000	Financial Controller	Unchanged
Computershare invoices (nursery vouchers)	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged
	Over £5,001 and Up to £50,000	Financial Controller	Unchanged
	Up to £5,000	Deputy Financial Controller	No limit

3. **Other Payments**

Payment Type	Amount	Responsible Officer	Current approver
All payment types below	Over £250,000	Director of Finance	Unchanged
	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged
NHS Supply Chain invoices for 'top up' of materials management	Up to £50,000	Approved by Financial Controller/Deputy Financial Controller	Unchanged
Payroll Payments	Main Trust Payroll	Director of Finance or Deputy in his/her absence	Unchanged
	Supplementary Payroll	Up to £30,000 Deputy Director of Finance or Financial Controller, otherwise Director of Finance	
	ENH Pharma Payroll	Pharma Director of Finance, Deputy Director of Finance or Financial Controller up to £200,000, otherwise Trust Director of Finance	
	Garden House Hospice Payroll	As per Supplementary Payroll above	
Payroll deduction payovers, such as Union subs, Court Orders, Tax/NI and Pension Scheme	If these reconciled to approved payrolls as above	Deputy Director of Finance or Financial Controller	

payments			
'Faster' Payments, based on approved invoices or payroll requests	Up to £50,000	Financial Controller or Deputy Financial Controller	

4. **Capital Expenditure**

The 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 IG to ensure that all Estates, Equipment and IT implications have been considered before it can be approved. 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 (discretionary)	Any	None – these require approval by HM Treasury	Unchanged

Payments in connection with Employment Disputes e.g. Employment Tribunals	Over £50,001	Trust Board (or Chair and Chief Executive on behalf of the Board)	Unchanged
	Between £10,001 and £50,000	Chief People Officer and Chief Executive	Unchanged
	Up to £10,000	Chief People Officer or Director of Workforce	Unchanged

7. **Credit Note Requests**

The limits below relate to the raising of credit notes which, although valid, will impact on the amount of income reported. Where errors in raising invoices have been made, cancellation of the incorrect invoice can be authorised by the Financial Controller/Deputy Financial Controller on the provision of evidence that the invoice will be re-raised correctly.

Invoice Type	Amount	Responsible Officer	Current approver
SLA/NCA Income from Commissioners	Up to £1,000	Assistant Director of Finance (Income and Contracts)	Unchanged
	Over £1,001 to £50,000	Assistant Director of Finance (Financial Planning) or Financial Controller	
	Over £5,001 and up to £500,000	Deputy Director of Finance	
	Over £500,001	Director of Finance	
Other Operating Income raised through Management Accounts	Up to £5,000	Deputy Financial Controller	
	Over £5,001 and up to £50,000	Assistant Director of Finance or Financial Controller	
	Over £50,001 and up to £500,000	Deputy Director of Finance	
	Over £500,001	Director of Finance	
Private Patient/Overseas Visitors Invoices	Up to £5,000	Deputy Financial Controller	

	Over £5,001 and up to £50,000	Financial Controller or Assistant Director of Finance	
	Over £50,001 and up to £500,000	Deputy Director of Finance	
	Over £500,001	Director of Finance	

8. **Losses and Special Payments**

Category	Amount	Responsible Officer	Current approver
Bad debts Write-Off (must always have dual signatories)	Up to £1,000	Financial Controller plus One Assistant Director of Finance	Unchanged
	Over £1,001 and up to £5,000	Financial Controller or Assistant Director of Finance plus Deputy Director of Finance	
	Over £5,001 and up to £100,000	Financial Controller, Assistant or Deputy Director of Finance plus Director of Finance	
	Over £100,001 and up to £250,000	Chief Executive and Director of Finance	
	Over £250,001	Board	
Fraud/Theft	All values	To be reported to Audit 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**

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 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	Charity Director (if within approved annual budget)	New limit
Other expenditure	Up to £500	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.

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~~16 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 2027** **(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~~Version: 16** **(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

	☐ **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**

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

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**

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****	30-06-2025 ☒Meeting date ☐Email date	☐Content contribution ☐Read and agree fit for use ☒Other: Approval

Commented [KC1]: To be updated

***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

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~~16 - STANDING ORDERS, SCHEME OF RESERVATION AND DELEGATION and SFIs
Due date of next full review	31 March 2027
Document type	Constitutional Policy
Version type	~~Version: 15~~Version: 16
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	**For completion by Policies Compliance Group** Record of formal agreement this version is fit for use at the Trust by **Policy Compliance** ... held on **YYYY-MM-DD**.
Governance checks	ADMIN USE ONLY

Commented [KC2]: To be updated

*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**	12	
Report title	2026-27 Board Assurance Framework (BAF) – Strategic risk register		**Meeting Date**	13 May 2026	
Author	Head of Corporate Governance				
Responsible Director	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 is to agree the 2026-27 BAF risks. The full proposed risks descriptions to form the 2026-27 BAF are enclosed as Appendix 1, for Board review and approval, including are the proposed oversight committees and executive leads optimal?

There is a healthy level of change and continuity reflecting robust consideration at the 15 April Board Seminar and follow-on 21 April BAF session. The following three risks have remained the same (or with relatively minor changes): Risk 2 Health inequalities (the same focus but improved wording); Risk 3 System and internal financial constraints; Risk 10: Digital transformation (with AI added).

The key proposed changes to the 2026-27 BAF are:

- Revised Risk 1: “Estates infrastructure to meet growing demand” replaces “Investment (capital, system allocation and no growth)” in the context there has been significant capital investment, highlighting the risk has matured more into estates capacity and constraints to meet future needs.

- New Risk 4: “Patient engagement, involvement and public accountability”, reflecting growing Board focus on ensuring robust arrangements are in place.

- New Risk 5: “Employee relations” replaces “Workforce morale whilst making necessary staffing savings” to focus on broader employee relations and not just in relation to savings.

- New Risk 6: “Leadership destabilisation and transition” replaces “Leadership and engagement”, moving the focus to managing the imminent change of senior leaders with the Chief Executive leaving and the Senior Independent Director and Board Vice-Chair coming to the end of their final terms in the next 8 months.

- Revised Risk 7: “Accountability consequences & ownership” replaces “Compliance culture and accountability” reflecting the desire for more focus on ownership and consequences.

- New Risk 8: “OneEPR” replaces “System instability” reflecting the importance of delivery of an effective EPR.

- Revised 9: “Demand, capacity and flow” replaces “Flow and performance”. At 21 April session, there was debate whether to expand this risk to wider performance but agreement was reached to keep the risk focused on demand and flow rather than becoming too broad and it was agreed to delegate the drafting of the risk to the COO.

- New Risk 11: “Failure to deliver transformation and achieve financial sustainability” replaces “Change management” was identified as a crucial addition to the BAF and tackling this risk was agreed as a key plank to delivering our wider strategy. The 21 April session merged two initially identified new risks into one: “Failure to deliver transformation” and “Reducing running costs”.

Next steps: Lead committees will then have the opportunity to review and fine-tune risk description wording and present back to the Board any proposed wording changes for approval. Controls, assurances and gaps will be worked up for lead committee consideration.

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 proposed BAF covers the above highlighted impacts and the BAF is intended to improve outcomes in all these areas.

The top three Thriving People risks have all changed significantly in the context all three Thriving People risks were also changed the previous year. Equally there are common themes running through the Thriving People BAF risks over the last three iterations: culture; leadership; accountability. All the other three strategic objectives have seen a mixture of continued and new risks over the last three iterations.

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*

Significant consideration was also given to whether the following risks should be added to the BAF. All were recognised as high-scoring risks that need particular attention, but following debate Board members concluded they better fitted on the Corporate Risk Register as significant operational rather than strategic risks:

- Cyber security
- Health emergency/pandemic
- Supply chain

These risks have been highlighted to the Risk Manager for consideration at the next Risk Management Group.

Report previously considered at & date(s):

At the 15 April 2026 Board Seminar and a follow-on session on 21 April, Board members carried out a horizon-scanning exercise to help identify the biggest risks to delivering the four strategic objectives. Changes since the version circulated after the Board Seminar are set out in Appendix 1 in green.

Recommendation	The Board is asked to: • identify any amendments or improvements to the proposed 2026-27 BAF risks or risk descriptions; • approve the 2026-27 BAF risks; and • confirm the proposed lead committees and executive leads.

To be trusted to provide consistently outstanding care and exemplary service

APPENDIX 1: 2026-27 PROPOSED BAF RISKS

KEY
Red: Signifies changes from the 2025/26 BAF
Green: signifies changes made after the 15 April Seminar session either at 21 April session or by lead executives after that
~~Strike-through~~: shows the 2025/26 BAF for reference

Quality of Care: Consistently deliver quality standards, targeting health inequalities and involving patients in their care			
No.	**Risk description**	**Lead Comm-ittee**	**Lead executive**
1	**Revised: Estates infrastructure to meet growing demand** **If** the Trust's estates and physical infrastructure is not capable of meeting changing patient and staff demand, due to legacy infrastructure and investment constraints **Then** the Trust will be unable to deliver safe, effective and timely services at the scale and quality required, and will have limited flexibility to redesign services, increase productivity or respond to system pressures and provide a satisfactory staff environment (including parking and accommodation) **Resulting** in non-delivery of clinical and operational objectives, increased risks to patient safety and experience, workforce inefficiencies and turnover, non-compliance with regulatory standards, reputational damage and reduced ability to achieve system priorities and long-term sustainability. ~~**2025-26 Investment (capital, system allocation and no growth)**~~ ~~**If** there is insufficient investment (capital, system allocation and no growth) to address rising costs, demand and aging infrastructure~~ ~~**Then** difficult choices will need to be made where to reduce costs or not to invest~~ ~~**Resulting** in services and infrastructure in those areas suffering and potential negative quality and safety impacts on patients and staff and increased risks to health and safety compliance.~~	FPPC	Estates Director
2	**Health inequalities (retained but fundamentally re-worded)** **If** we do not address health inequalities in line with mandated NHS expectations and ICB priorities including neighbourhood models **Then** avoidable variation in access, experience and outcomes will widen, particularly for our most deprived communities **Resulting** in avoidable excess mortality and morbidity, rising non-elective activity, loss of public confidence and heightened regulatory scrutiny, constraining our capacity to deliver planned care and system flow. ~~**2025-26 Health inequalities**~~ ~~**If** we do not address health inequalities nor meet the expectations of patients and other stakeholders~~	QSC	Medical Director

	~~**Then** population/stakeholder outcomes will suffer~~ ~~**Resulting** in poorer public health, loss of trust, loss of funding opportunities and regulatory censure and knock-on impacts on our ability to regulate front-door demand for non-elective services.~~		
3	**NO CHANGE: System and internal financial constraints** **If** far-reaching financial savings are required (either due to system financial instability or internal pressures), and we do not deliver greater efficiencies **Then** we will need to make difficult decisions that could have a negative impact on quality and delivery of our strategy **Resulting** in poorer patient outcomes, longer waiting times; reduced staff morale, reputational damage and not delivering all of our strategy.	FPPC	CFO
4	**NEW: Patient engagement, involvement and public accountability** **If** patient, carer and public engagement is disconnected from decision-making or is inconsistent or perceived as tokenistic and we fail to demonstrate transparency and accountability to our communities **Then** Trust decisions may lack legitimacy, fail to reflect lived experience, and attract increased scrutiny and challenge from patients, Healthwatch, local partners and regulators **Resulting in** regulatory action taken in response to inadequate patient / public responsiveness when concerns have been raised, erosion of public trust, increased complaints and judicial or media challenge, reduced engagement from seldom-heard groups, and constraints on our ability to transform services to meet the needs of the patients we serve and demonstrate effective Well-Led governance.	QSC	Director of Comms & Engagment

Thriving People: Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability			
45	**NEW: Employee relations** **If** the Trust is unable to maintain positive employee relations during periods of financial constraint and cost improvement and transformation delivery ~~and industrial action~~ **Then** workforce morale, engagement and stability may deteriorate, leading to reduced productivity, increased absence and disruption to service delivery. It could also lead to increased collective action such as working to rule, and/or collective grievance action **Resulting in** compromised patient safety and experience, failure to maintain safe staffing levels, adverse impacts on staff wellbeing, recruitment and retention, deterioration in quality and performance standards, and reputational and financial damage to the Trust. ~~**20256/26 Workforce morale whilst making necessary staffing savings**~~ ~~**If** the Trust does not manage the necessary staffing savings approach well~~	P&C	CPO

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	~~**Then** staff morale and motivation could be affected~~ ~~**Resulting** in a range of issues arising from a disaffected workforce including reduced patient quality and safety, productivity and increased turnover and difficulty recruiting high calibre staff.~~		
~~5~~6	**NEW: Leadership destabilisation and transition** **If** the Trust does not effectively manage the Chief Executive leaving and NEDs retirement transition effectively including maintaining leadership stability, cohesion and clarity of authority **Then** there is a risk of wider leadership turnover, fragmented relationships within the leadership team and reduced strategic focus **Resulting** in derailing delivery of our strategy and impaired decision-making and loss of confidence from the workforce and stakeholders. ~~**2025/26 Leadership and engagement**~~ ~~**If** the Board and Executive do not effectively nurture and model the right leadership behaviours and skills and these standards are not adopted at all levels of the organisation~~ ~~**Then** sub-optimal management and behaviours in hotspot areas will occur and staff may not feel psychologically safe to raise concerns~~ ~~**Resulting in** being unable to make the transformation changes needed to improve patient services and core performance standards and staff experiencing stress, bullying, harassment and discrimination~~	P&C	CEO
~~6~~7	**REVISED: Accountability consequences & ownership** Alternative wording: **If** the Trust is unable to successfully implement the improvements to accountability, ownership and organisational culture, including embedding a clear and effective accountability framework with consequences **Then** performance and financial delivery and compliance with core standards will remain inconsistent **Resulting in** the Trust struggling to deliver key operational and financial outcomes (including cost improvement programmes), failure to consistently meet mandatory and statutory requirements (such as statutory and mandatory training), and reduced capacity to deliver the wider cultural, transformational and service improvements required to achieve the Trust's strategic objectives. ~~**2025-26 Compliance culture and accountability**~~ ~~**If** the desired accountability approach and framework changes are not achieved~~ ~~**Then** compliance and appropriate action and consequences will remain sub-optimal~~ ~~**Resulting** in the Trust struggling to deliver key outcomes such as CIPs, mandatory requirements such as statutory and mandatory training, as well as wider needed changes and improvements.~~	P&C	CPO

Seamless services: Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners			
~~7~~8	**NEW: OneEPR** **If** the OneEPR programme is further delayed or fails without an effective mitigation or contingency approach **Then** the Trust's digital capability will be insufficient to support modern healthcare delivery **Resulting in** not being able to mitigate for patient safety and information governance risks, significant inefficiencies in clinical and administrative workflows, failure to realise planned benefits and CIPs, and loss of credibility with regulators and system partners. ~~**2025/26 System instability**~~ ~~**If** significant and rapid changes are made to NHS oversight and delivery structures~~ ~~**Then** decision making may be slowed due to increased ambiguity or management capacity~~ ~~**Resulting in** important transformation not keeping pace with patient need.~~	Digital	CIO
~~8~~9	**REVISED: Demand, capacity and flow** **If** we do not achieve further improvements to clinical pathways, matching capacity to demand, and flow within the Trust and wider system, including left shift **Then** patients will experience prolonged waits, delays in treatment and fragmented care pathways; pressures will continue to escalate across ENHTT and partner organisations; and the Trust's key (NOF) performance metrics will not be achieved **Resulting in** poor patient experience, poor quality care and adverse outcomes, wider health improvements not being delivered; increased scrutiny or intervention from regulators and commissioners and reputational damage ~~**2025-26 Improving flow and performance**~~ ~~**If** we do not achieve the improvements in flow within the Trust and wider system~~ ~~**Then** the Trust's key performance targets will not be met~~ ~~**Resulting** in poor quality care and adverse outcomes, wider health improvements not being delivered and regulatory censure~~	FPPC	COO
~~9~~	~~**2025-26 Future of cancer services**~~ ~~**If** the future of cancer services at Mount Vernon and Lister is not resolved promptly by strategic partners~~ ~~**Then** there is a risk of unplanned reconfiguration of cancer services and the inability of the Trust to undertake long-term strategic planning that is financially viable~~ ~~**Resulting** in fragmented clinical care with the inability to optimise clinical outcomes; material financial destabilisation; the inability of the Trust to deliver its legal duties; and reputational damage.~~	FPPC	COO

Continuous improvement: Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities			
10	**AMENDED: Digital transformation & AI** **If** the necessary digital and AI transformation improvements are not prioritised, funded or delivered **Then** the Trust will lack the digital means to deliver its plans including using obsolete legacy systems that are unsupportable **Resulting** in 1) not delivering transformation plans that are crucial to improving efficacy *and productivity* 2) not achieving the nationally mandated minimum digital foundations and 3) a failure to optimize patient experience and quality of care	Digital	CIO
11	**NEW: Failure to deliver transformation and achieve financial sustainability** **If** the Trust is unable to deliver its transformation programmes at the required pace and scale and is unable to reduce running costs and deliver sustainable financial improvement **Then** existing services and operating models will remain inefficient and unaffordable, financial balance will not be achieved, and productivity and quality improvements will not be realised **Resulting in** the risk of compromising safe, effective and high-quality care; continued operational pressure; failure to deliver cost improvement and financial recovery plans; reduced ability to improve patient outcomes and quality of care; increased risk of regulatory intervention and censure; and an inability to deliver key elements of the Trust's strategic objectives. ~~**2025/26 Change management**~~ ~~**If** the Trust does not develop the change management capacity and capability required to transform its operations and performance~~ ~~**Then** the Trust will not increase its agility and adaptiveness and will continue to observe evidence a non-sub-optimal hierarchical culture which is resistant to change~~ ~~**Resulting in** not seizing opportunities to further our wider goals, improve productivity and morale and reduce waste~~	FPPC	CKO

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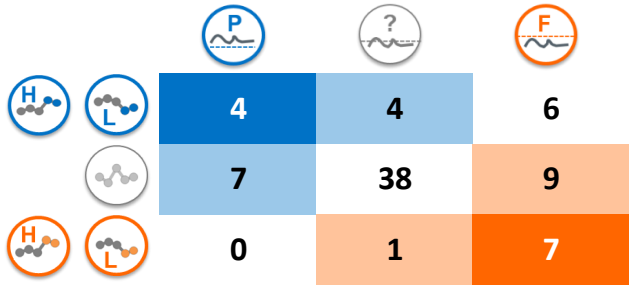
Integrated Performance Report

Month 12 | 2025-26



Data correct as at 22/04/2026

Performance Highlights

NHS East and North Hertfordshire Teaching NHS Trust

Quality

- Mortality, LOS and readmission rates stable.
- Stroke thrombolysis rate improving.
- Further work on Sepsis / VTE happening.
- IPC - stable - monitoring surgical site infections.

Operations

- **Urgent and Emergency Care:** Improvement reset from 1/3 delivered 74.7%: best 4 hr performance since Sept 25. 12 hrs: 7.9% vs trajectory of 5%; a 4% improvement on March 2025. Ambulance handover median 21 mins - 16% improved on March '25.
- **Cancer Waits**: Achieved 3/3 targets YTD to Feb.
- **Referral To Treatment (RTT)** (excluding Community Paeds): Delivered all 3 March targets, exceeding 18 weeks target by 5%. Upper quartile performance nationally.
- **Community waits**: Herts COOs leading on acceleration of integrated CYP Neurodiversity pathway.
- **Diagnostics**: positive shift in waits over 6/52 both volume and & over last 6/12. Audiology, MRI & NOUS actions continue.

Finance

- £5.0m surplus delivered, reliant on £4.9m national deficit funding and other non-recurrent measures.
- Underlying position materially adverse, reflecting structural deficit.
- CIP £16.5m shortfall – primary driver of financial risk. Over 1/3rd of CIP target never identified. Actual 25/26 CIP delivered less than prior year.
- Workforce cost pressures and divisional overspends persist. Significant challenges remain regarding control of temp staffing.
- Elective performance and productivity gaps masked by block.
- 2026/27 position high risk; focus on transformation programme recurrent savings, grip and productivity.

People

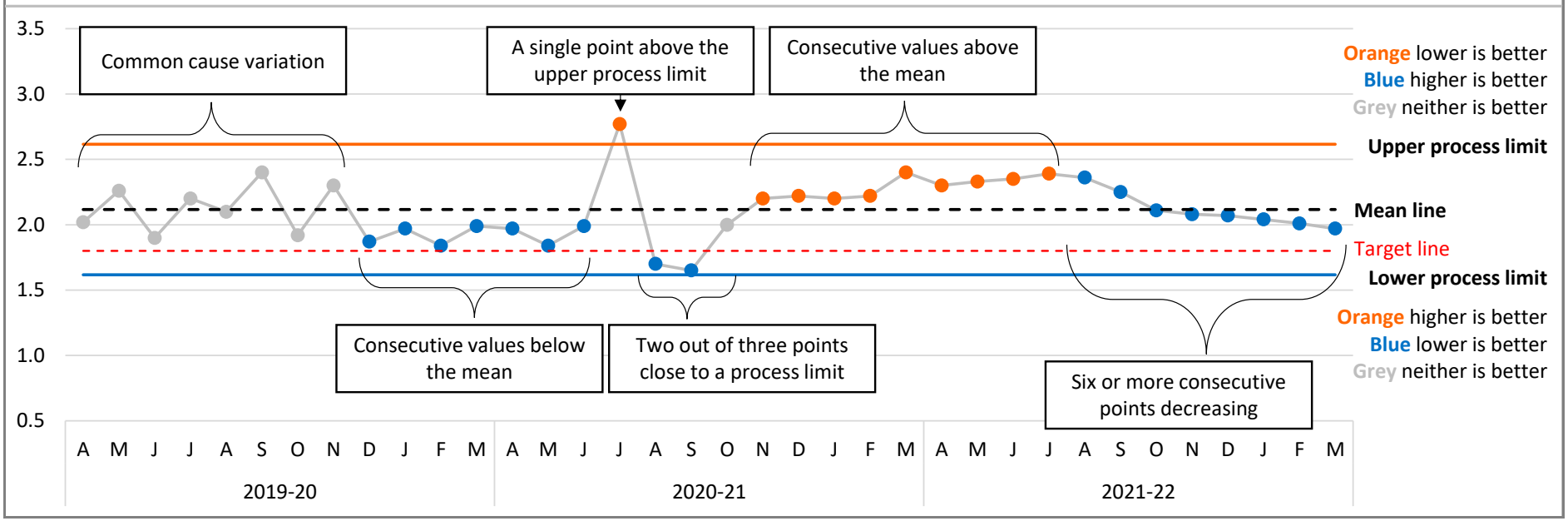
- Staff turnover rate reduced to 7.1% and remains below target.
- Overall Bank & Agency spend above target by 1.7%, usage against Bank costs as opposed to Agency which is 1.9% under target.
- GROW together compliance as well as Appraisal compliance remains static and under target, Medical appraisals now included.
- Stat Mand training compliance static - improvement paper provided at PCC with assurances around targeted interventions.
- Sickness target monitoring improving position vs previous month, stress & mental health conditions continue to be a leading cause of sickness absence.
- Vacancy rate remains under target (5.6%)
- No open suspensions across the organisation.

Month 12 | 2025-26

Integrated Performance Report

NHS East and North Hertfordshire Teaching NHS Trust

How to interpret a Statistical Process Control (SPC) Chart



Variation

H L	Special cause variation of **concerning** nature due to **H**igher or **L**ower values
H L	Special cause variation of **improving** nature due to **H**igher or **L**ower values
	Common cause variation No significant change

Assurance

F	Consistent Failing of the target Upper / lower process limit is above / below target line
P	Consistent Passing of target Upper / lower process limit is above / below target line
?	Inconsistent passing and failing of the target

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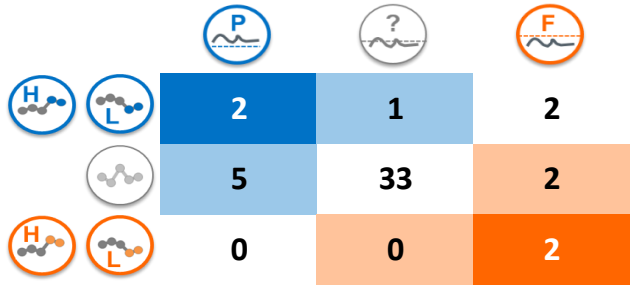
Quality

Month 12 | 2025-26



Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	Mar-26	n/a	1,645			Common cause variation No target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Mar-26	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Mar-26	0	6		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Mar-26	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Mar-26	0	5		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Mar-26	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Mar-26	0	0	L	?	7 points below the mean Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Mar-26	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Mar-26	80%	91.7%		P	Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	Mar-26	n/a	87.9%			Common cause variation No target
	Staff shortage incidents	Mar-26	n/a	8			Common cause variation No target

Month 12 | 2025-26

Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	Mar-26	n/a	0.51			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Mar-26	n/a	1.44			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Mar-26	95%	81.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Mar-26	95%	63.6%		F	Common cause variation Metric will consistently fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Mar-26	95%	91.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Mar-26	95%	63.2%	L	F	13 point below the mean Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Mar-26	85%	79.0%		F	Common cause variation Metric will consistently fail the target
HATs	Number of HAT RCAs in progress	Mar-26	n/a	251	H		13 points above the upper process limit No target
	Number of HAT RCAs completed	Mar-26	n/a	26			Common cause variation No target
	HATs confirmed potentially preventable	Mar-26	n/a	2			Common cause variation No target
PU	Pressure ulcers All category ≥2	Mar-26	0	9		?	Common cause variation Metric will inconsistently pass and fail the target

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Quality

Summary

East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Falls	Rate of patient falls per 1,000 overnight stays	Mar-26	n/a	3.4			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Mar-26	n/a	3.8%			Common cause variation No target
Other	National Patient Safety Alerts not completed by deadline	Sep-24	0	0			Metric unsuitable for SPC analysis
Friends and Family Test	Inpatients positive feedback	Mar-26	95%	96.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	A&E positive feedback	Mar-26	90%	86.1%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Mar-26	93%	100.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Birth positive feedback	Mar-26	93%	100.0%	H	P	10 points above the upper process limit Metric will consistently pass the target
	Maternity Postnatal positive feedback	Mar-26	93%	96.4%		?	Common cause variation Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	Mar-26	93%	100.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Outpatients FFT positive feedback	Mar-26	95.0%	94.8%		?	Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Mar-26	n/a	388		-	Common cause variation No target

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Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Complaints	Number of written complaints received in-month	Mar-26	n/a	94		-	Common cause variation No target
	Number of complaints closed in-month	Mar-26	n/a	82		-	Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	Mar-26	75%	88.9%		P	Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	Mar-26	80%	31.9%	L	F	10 points below the mean Metric will consistently fail the target
Maternity Safety Metrics	Caesarean section rate Total rate from Robson Groups 1, 2 and 5 combined	Jul-24	60 - 70%	70.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml vaginal	Mar-26	3.3%	3.0%		?	Common cause variation Metric will inconsistenly pass and fail the target
	3rd and 4th degree tear vaginal	Mar-26	2.5%	1.5%		?	Common cause variation Metric will inconsistenly pass and fail the target
	Massive obstetric haemorrhage >1500ml LSCS	Mar-26	4.5%	2.0%		?	Common cause variation Metric will inconsistenly pass and fail the target
	3rd and 4th degree tear instrumental	Mar-26	6.3%	1.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	Term admissions to NICU	Mar-26	6.0%	4.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	ITU admissions	Mar-26	0.7	0		?	Common cause variation Metric will inconsistently pass and fail the target

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Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Maternity Other Metrics	Smoking at time of booking	Mar-26	12.5%	4.5%			Common cause variation Metric will consistenly pass the target
	Smoking at time of delivery	Mar-26	2.3%	4.3%			Common cause variation Metric will inconsistently pass and fail the target
	Bookings completed by 9+6 weeks gestation	Mar-26	50.5%	70.7%			Common cause variation Metric will consistenly pass the target
	Breast feeding initiated	Mar-26	72.7%	75.4%			Common cause variation Metric will inconsistently pass and fail the target
	Number of MNSI PSII	Mar-26	0.5	1			Common cause variation Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	Mar-26	12.8	6.6			Common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	Mar-26	12.8	8.7			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Jan-26	100	75.7			Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Jan-26	100	85.5			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Nov-25	100	91.9			Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Nov-25	100	94..4			Rolling 12-months - unsuitable for SPC

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Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Re-admissions	Number of emergency re-admissions within 30 days of discharge	Jan-26	n/a	614	L		1 point below the lower process limit No target
	Rate of emergency re-admissions within 30 days of discharge	Jan-26	9.0%	5.1%	L	P	1 point below the lower process limit Metric will consistently pass the target
Length of Stay	Average elective length of stay	Mar-26	2.8	2.2		P	Common cause variation Metric will consistently pass the target
	Average non-elective length of stay	Mar-26	4.6	5.0		?	Common cause variation Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Mar-26	n/a	93.2%			Common cause variation No target
	Individualised care pathways	Mar-26	n/a	28			Common cause variation No target
Stroke Services	Trust SSNAP grade	Q4 2024-25	A	D			
	4-hours direct to Stroke unit from ED	Mar-26	63%	33.0%	H	F	9 points above the mean Metric will consistently fail the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	Mar-26	63%	37.0%	H	F	9 points above the mean Metric will consistently fail the target
	Number of confirmed Strokes in-month on SSNAP	Mar-26	n/a	78			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Mar-26	80%	75.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Urgent brain imaging within 20 minutes of hospital arrival for suspected acute stroke	Mar-26	40%	38.0%			Not enough data for SPC
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Mar-26	50%	65.0%		?	Common cause variation Metric will inconsistently pass and fail the target

Month 12 | 2025-26

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
	% of all stroke patients who receive thrombolysis	Mar-26	11%	20.0%			Common cause variation Metric will inconsistently pass and fail the target
	Discharged with ESD	Mar-26	50%	66.0%			Common cause variation Metric will inconsistently pass and fail the target

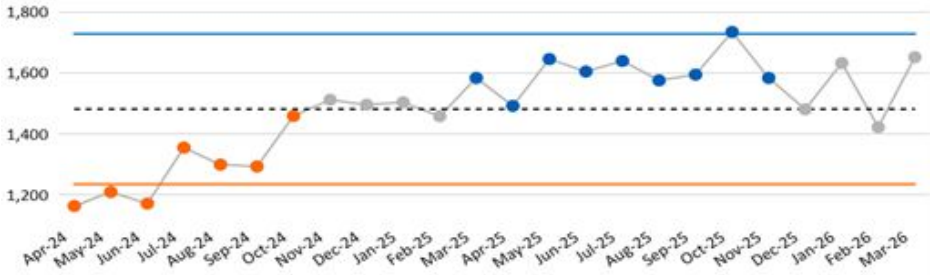
Month 12 | 2025-26

Quality

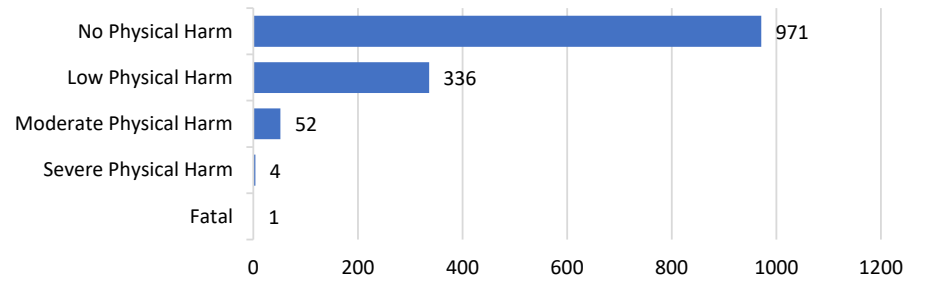
Patient Safety Incidents

NHS East and North Hertfordshire Teaching NHS Trust

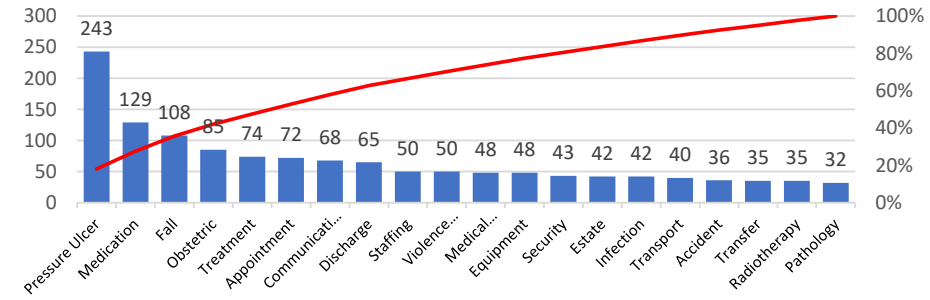
Total incidents reported



Number of patient safety incidents by level of harm - Mar-26



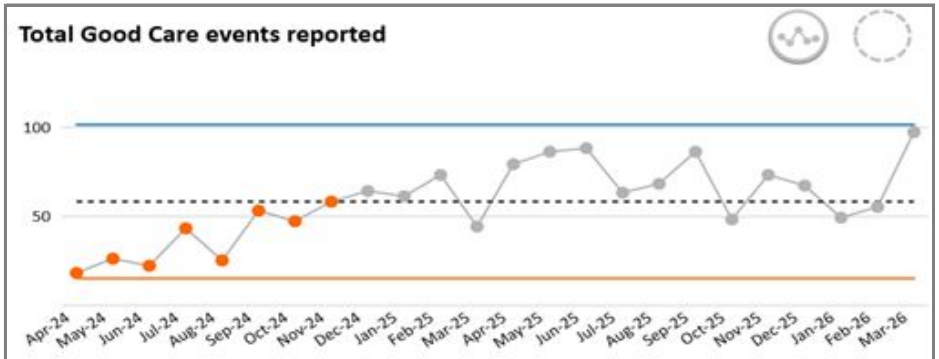
Incidents Themes - Mar-26



Key Issues and Executive Response

- Continued common cause variation in incident reporting
- 96% of incidents reported resulted in no harm / low harm, in line with previous months.
- Obstetrics and Emergency Medicine continue to be the highest reporting specialties with incidents reported in Emergency Medicine returning to usual levels following reduction in February.
- Positive increase in incident reporting in Gynaecology following active promotion across Women's services (no increase in patient harms)
- Increase in incidents regarding medical records due to ongoing issues with availability of medical records and roll out of Mediviewer system. Significant impact seen in Women's services and Planned Care. Associated risk recorded on risk register.
- Ongoing learning review in Plastics following potential wrong site surgeries - early learning identified regarding use of WABA and documentation.
- 1 new PSii commissioned reviewing fundamentals of nursing care. Early family engagement has already taken place. Targeted supportive work being provided to ward and observational work starting. Learning response team includes external Nurse, pharmacist, therapist and senior Nurse from ENHT.

Total Good Care events reported



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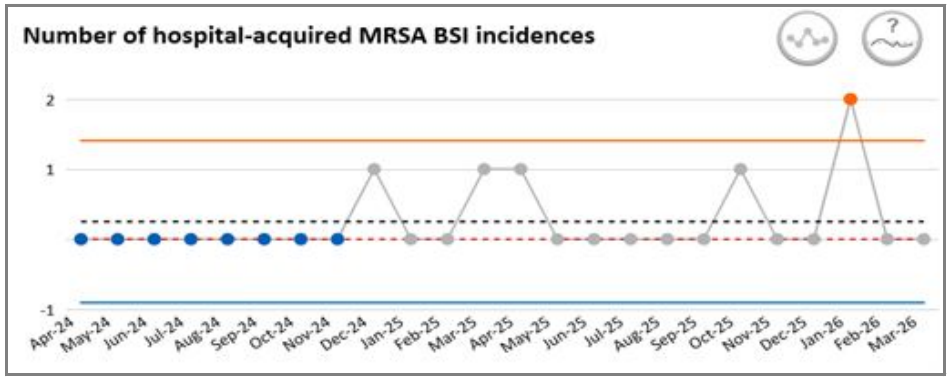
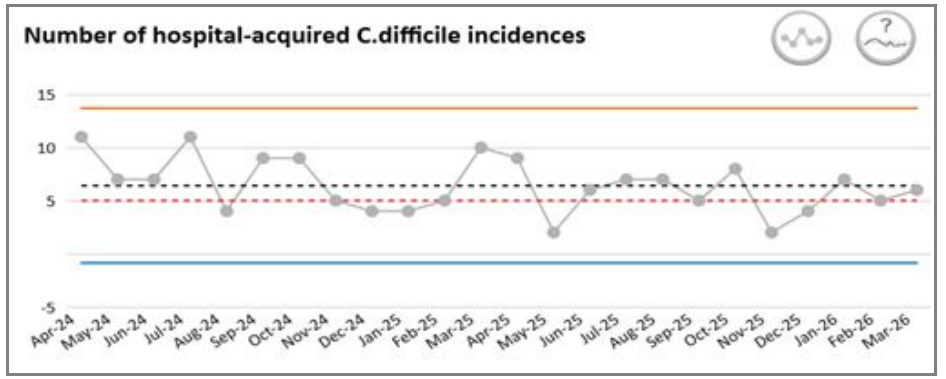
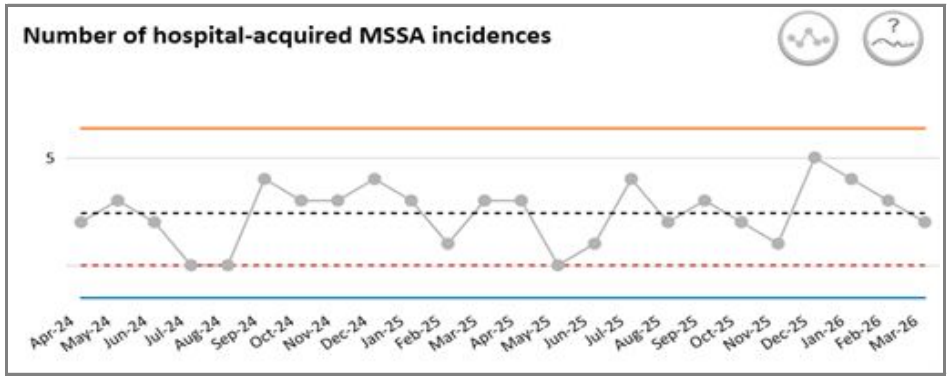
Quality

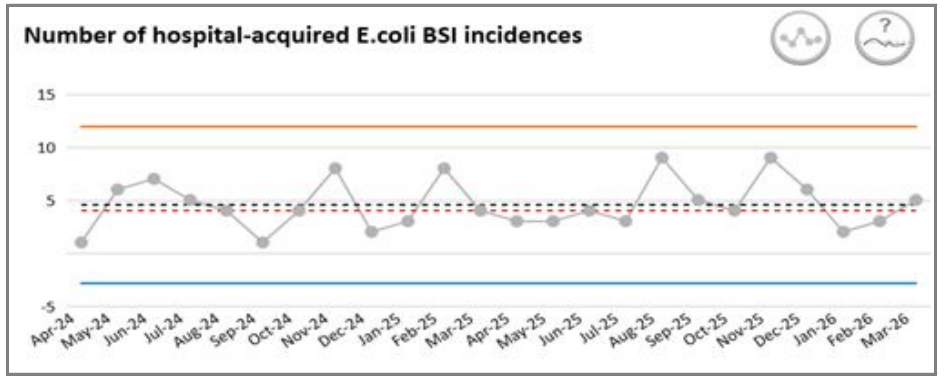
Infection Prevention and Control

East and North Hertfordshire Teaching NHS Trust









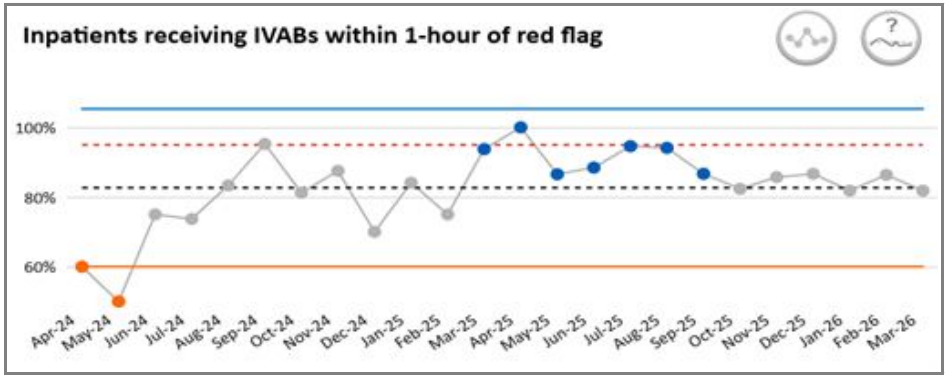
- MRSA BSI - there were no MRSA Bloodstream Infections (BSI) reported during Mar'26. For the financial year (FY) 2025-26, four MRSA BSI have been reported, with an annual threshold of zero. Post infection reviews (PIRs) were completed for each case, and actions were reviewed and monitored through infection prevention and control (IPC) and divisional meetings.
- MSSA BSI - there were two MSSA BSI identified during Mar'26. A Total of 29 MSSA BSI were reported during the FY 2025-26, with no annual threshold. All cases were reviewed with the themes and learning identified informing ongoing infection prevention activity.
- C. difficile (C diff.) infection (CDI) - six cases of hospital associated CDI were reported during Mar'26. For the FY 2025-26, a total of 68 cases have been reported. Performance remains below the annual threshold of 82. All cases were reviewed in line with Trust processes, with learning and actions monitored through IPC and divisional meetings.
- E.coli BSI - there were five E.coli BSI reported during Mar'26. For the FY 2025-26, 56 E.coli BSI have been identified, which is above the annual threshold of 46. Surveillance and monitoring continues to highlight areas of good practice and areas of practice needing improvement.

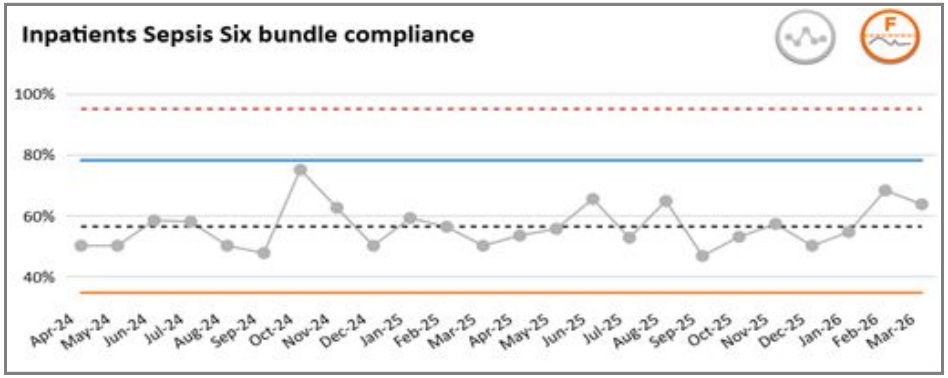
Month 12 | 2025-26

Quality

Sepsis Screening and Management | Inpatients

East and North Hertfordshire Teaching NHS Trust





Themes

Sepsis IP	2025-26											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	73%	92%	81%	86%	94%	94%	73%	81%	92%	57%	91%	73%
IV antibiotics	94%	100%	88%	87%	94%	94%	87%	82%	86%	86%	82%	82%
IV fluids	79%	89%	100%	89%	93%	92%	100%	82%	92%	100%	88%	82%
Lactate	81%	57%	81%	73%	71%	76%	50%	81%	64%	71%	82%	64%
Urine measure	88%	93%	89%	93%	68%	88%	80%	82%	93%	75%	73%	73%
Sepsis Six bundle												

Key Issues and Executive Response

Themes

- 7/11 patient audits demonstrated sepsis six compliance, achieving 6/6 elements within the hour.
- IV antibiotic compliance shows normal variation, sitting at 82% in February, whilst IV fluids sits at 82%.
- Lactate measurement dipped in March to 64%, however a smaller sample size of patients were obtained compared to in February.
- Urine output measurement sits at 73% compliance in February.
- Blood culture compliance similarly to lactate dropped to 73%, showing a need to focus on prompt blood taking in septic patients across education in April.
- 2/11 patients received antibiotics outside the target hour, both of which were delays through delayed prescribing, decision making and administering.

Response

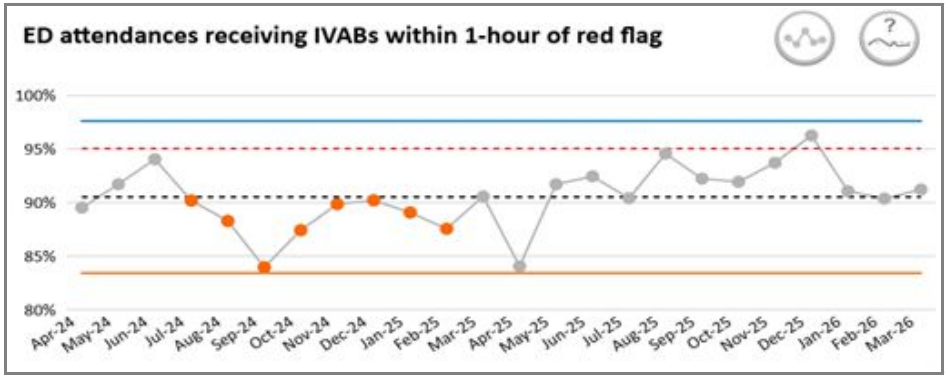
- All delays have been Enhanced and sent to relevant teams and ward managers to investigate as appropriate.
- The team are working closely with Orbis to ensure the new EPR system reflects the need for sepsis screening and fluid balance charts.
- The team are utilising formal and bedside education, alongside working with practice educators to push for sustainability in compliance.
- Supporting the AMU team to undertake a fluid balance quality improvement project.
- The sepsis team is running a MDT Sepsis simulation day in March, alongside a Sepsis/AKI study day for nurses, csw's, and students.
- FY2 teaching for the medical teams was undertaken with further scheduled later in the year.
- The team are trying to intercept unwell septic patients and assist in the delivery of the sepsis six in a timely manner.

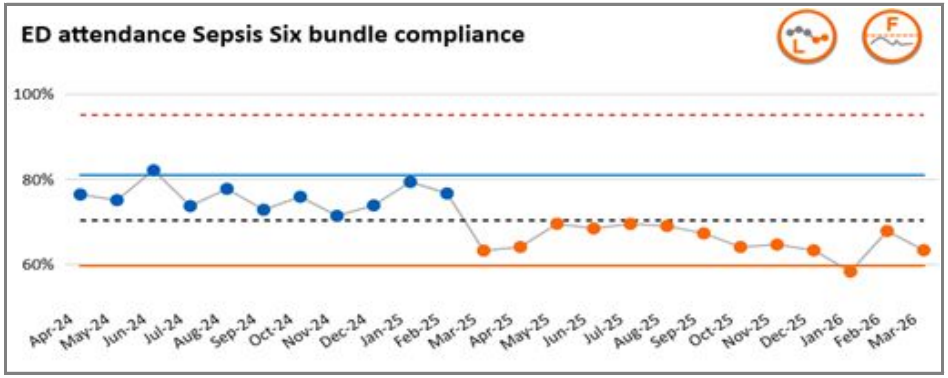
Month 12 | 2025-26

Quality

Sepsis Screening and Management | Emergency Department

East and North Hertfordshire Teaching NHS Trust





Themes

Sepsis ED	2025-26											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	96%	88%	96%	92%	96%	95%	92%	97%	94%	95%	96%	96%
IV antibiotics	91%	84%	92%	92%	90%	95%	92%	92%	94%	96%	91%	91%
IV fluids	90%	89%	91%	99%	93%	94%	93%	94%	98%	100%	97%	90%
Lactate	97%	96%	99%	99%	100%	97%	100%	99%	97%	100%	99%	100%
Urine measure	68%	73%	75%	77%	73%	73%	70%	68%	66%	67%	62%	68%
Sepsis Six bundle												

Key Issues and Executive Response

Themes

- 43/68 ED patient audits demonstrated sepsis compliance, with 63% having all six elements completed within an hour in March.
- Urine output sits at 68%, a drop from February, highlighting the on-going lack of consistency completing fluid balances, and is responsible for a dropping overall sepsis six compliance.
- Lactate and blood culture collection have maintained compliance and remain above target throughout the whole of Q4.
- IV antibiotic compliance sits consistently at 91% with 62/68 patients receiving antibiotics within 1 hour with the longest time to being 2hr12mins.
- IV fluid administration compliance dipped slightly to 90% with 54/60 receiving within the hour, this seems to be an anomaly when looking at previous months trends.
- Oxygen saturations remain at 100%.

Response

- The Sepsis Team continue to attend patients in ED assessing and going through the Sepsis Screening Tool in real time. Whilst in the department the team utilises this as a education opportunity and works with the team to improve sepsis management.
- Further discussions with ED practice development team and matrons about improving fluid balance compliance, for which we are starting ED Team time in April for 12 weeks with a focus on fluid balance monitoring through scenario based education.
- ED have updated and improved a sepsis education/notice board for reference in the department.
- The team remains available on Alertive for referrals, queries and support for staff in ED.

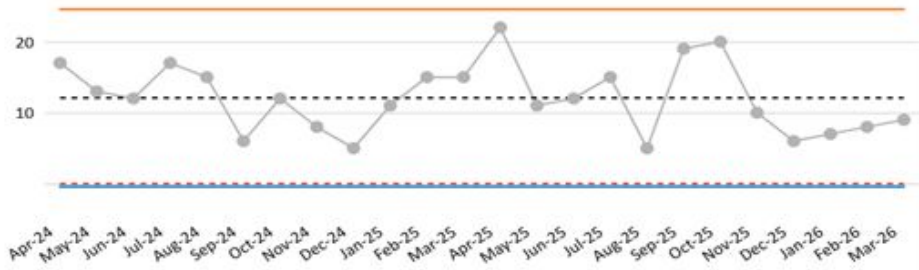
Month 12 | 2025-26

Quality

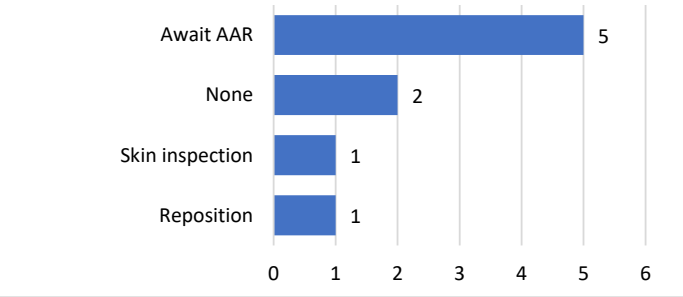
Pressure Ulcers | VTE

East and North Hertfordshire Teaching NHS Trust

Number of hospital-acquired pressure ulcers



Themes - Mar-26



415

days since last category 4

as at 22/04/2026

VTE risk assessment stage 1 completed

Key Issues and Executive Response

Pressure Ulcers

- 2025-26 HA PU is consistent with previous year data.
- A steady decline in HA PU figures is noted from Oct 2025.
- From August 2025 - March 2026, Links have conducted a PU audit focusing on NICE CG179 and NICE QS89 and providing peer education.
- Heel PUs continue to be the leading cause of PUs in the trust. Targeted improvement work using one of the ENH PS tools 5Ss, heel protection stock has been standardised to ensure availability when required.
- Ongoing weekly Division Pressure Ulcer Safety Huddle (DPUSH) aimed at addressing HA PU concerns and providing early interventions, support/immediate actions.
- Plan to adopt PURPOSE-T PU prevention risk assessment tool is in progress. This will be implemented in 2026, when the new EPR system is rolled out.

VTE

- In October 2024, in accordance with NHSE requirements the Trust adopted a 14-hour timeframe for the completion of VTE risk assessments. This change resulted in an anticipated reduction in reported compliance due to the application of more stringent reporting parameters.
- The decline in compliance with VTE risk-assessment completion observed from July and December '25 is likely attributable to industrial strike action. This is likely to be seen in April ' 26 data with the current on-going strike action.
- There is a need to ensure that most "day-case" patients are also being risk assessed - after clarity provided by NHSE on VTE audit data requirements and inclusion criteria.

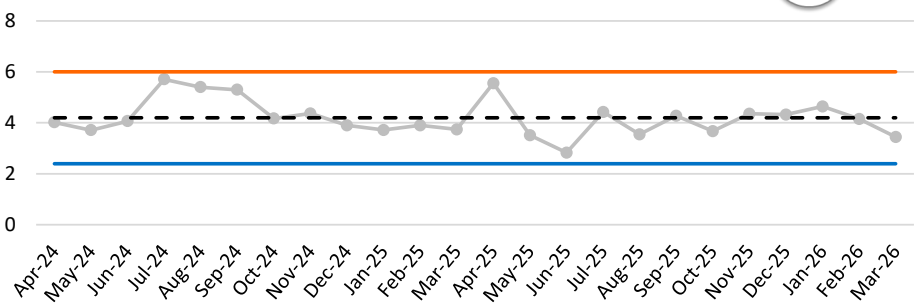
Month 12 | 2025-26

Quality

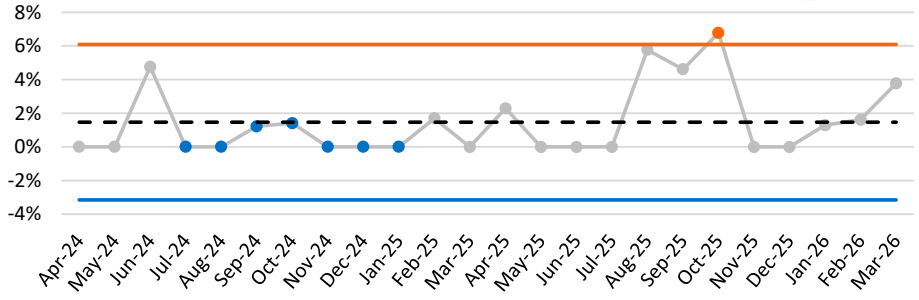
Patient Falls

NHS East and North Hertfordshire Teaching NHS Trust

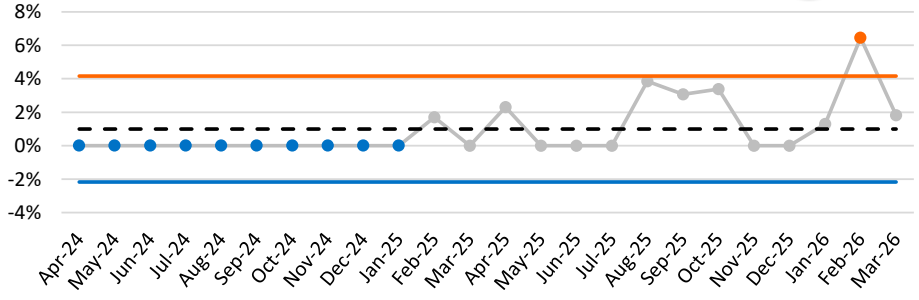
Rate of patient falls per 1,000 overnight stays



Proportion of patient falls resulting in Severe physical harm



Proportion of patient falls resulting in Moderate physical harm



Key Issues and Executive Response

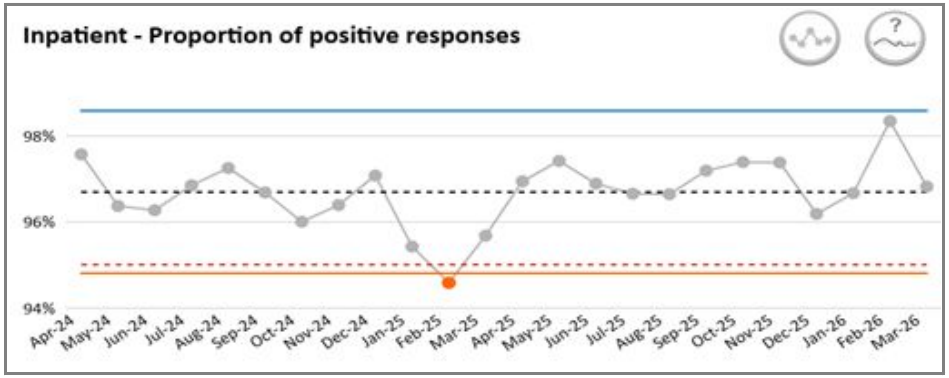
- Inpatient falls data continues to show common cause variation, with an average of 4 per month per 1000 bed days.
- In March, three falls resulting in moderate or serious harm were recorded, all of which were unwitnessed. Two of these incidents did not have an updated falls risk assessment in place. Additionally, one incident involved the use of inappropriate moving and handling equipment during patient transfer.
- These lapses in compliance have been communicated to clinical leaders, with the expectation that they will cascade this information to their teams to support improvement in adherence to safety protocols in line with the falls policy.
- Falls lead will link in to ED leaders to discuss improvement in compliance with falls documentation, adherence to falls recommendation, and appropriate escalations.

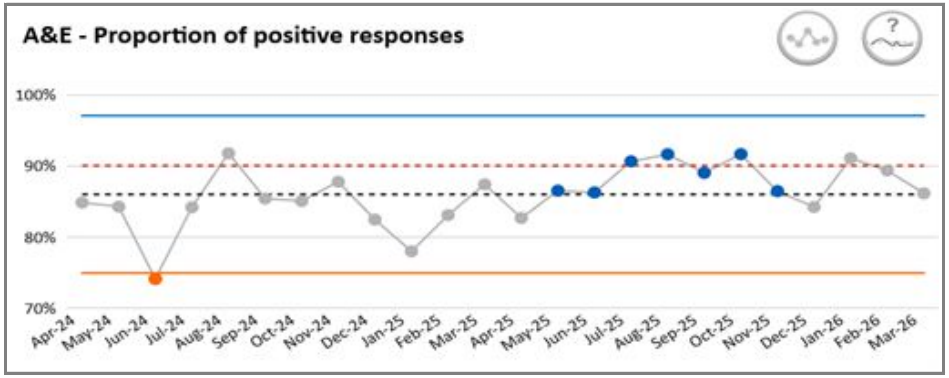
Month 12 | 2025-26

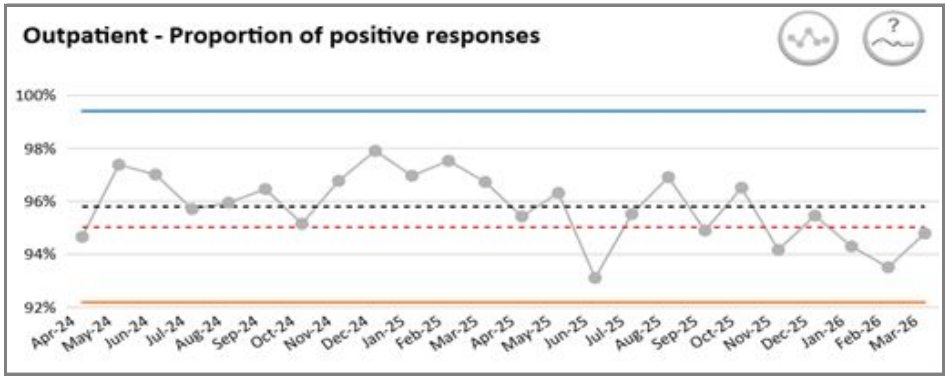
Quality

Friends and Family Test

East and North Hertfordshire Teaching NHS Trust







Key Issues and Executive Response

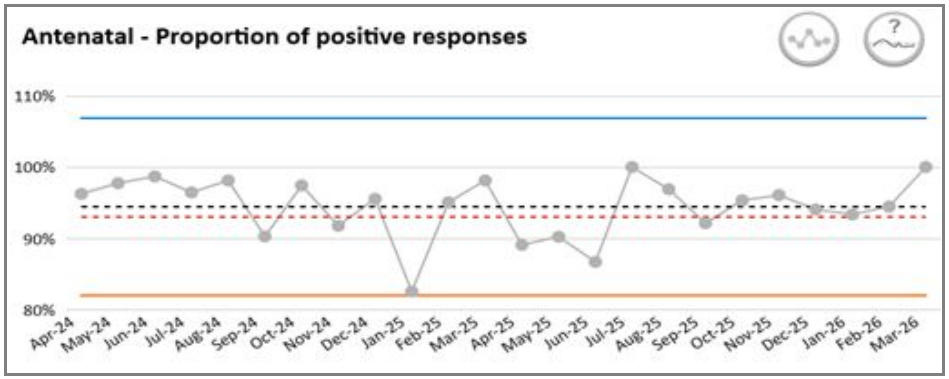
Friends and Family Test

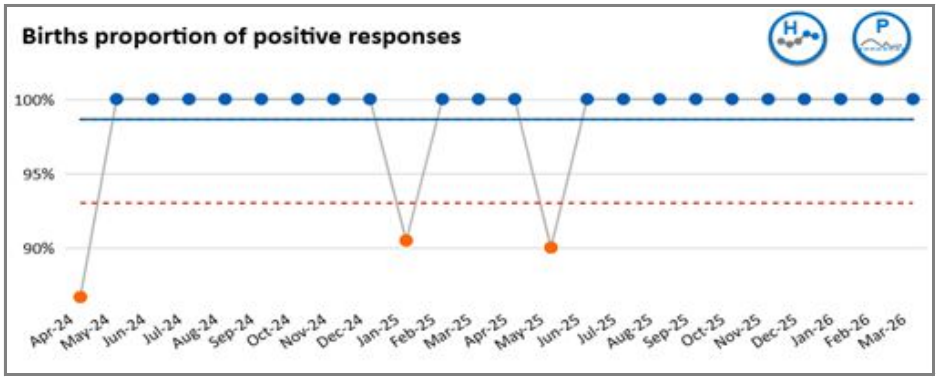
- A slight increase in number of responses received across the Trust for March compared with previous month. Overall Trust score remained comparable for % good/very good at 95.61% (95.56% Feb), with improvement in % poor/very poor to 1.52% (2.01% Feb).
- The number of discharges for inpatient/Day Case increased although overall response rate decreased to 19.43% (20.83% Feb). The proportion of positive responses also decreased to 96.81% (98.34% Feb) for % good/very good.
- There was an increase in the number of discharges in ED-UTC with a difference of +3,968 in March compared to the previous month although the proportion of positive responses dipped for a second month with the % poor/very poor increasing to 8.21% compared to 5.66% in February.
- Overall, outpatients had a slight increase in the total number of responses with the proportion of positive responses also increasing- % good/very good 94.77% (93.49% Feb). The % poor/very poor improved to 1.86% (3.31% in Feb).
- Mount Vernon CC outpatient service had the worse results overall in February and whilst still not improving significantly this month with the % good/very good at 87.04% (85.47% Feb), the % poor/very poor has decreased to 4.94% (11.63% Feb). The feedback indicates a dissatisfaction with delays in appointments and wait times.
- The number of responses for maternity postnatal remained the same, with a reduction in positive feedback and an increase in % poor/very poor - 0.95% (0.88% Feb). Themes include ward environment and noise levels.

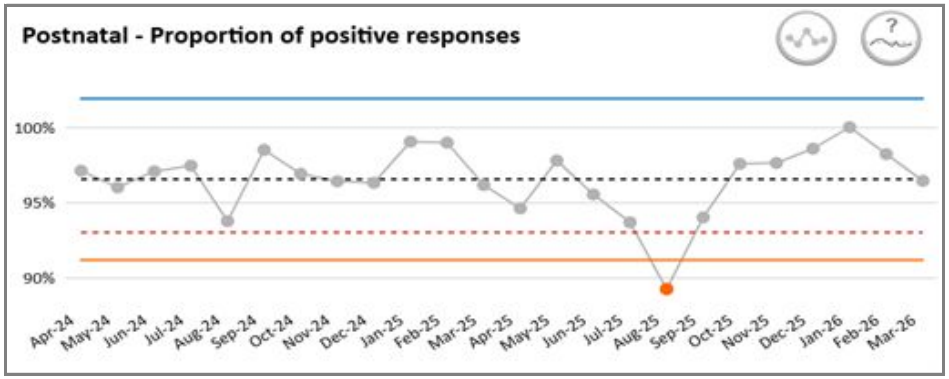
Month 12 | 2025-26

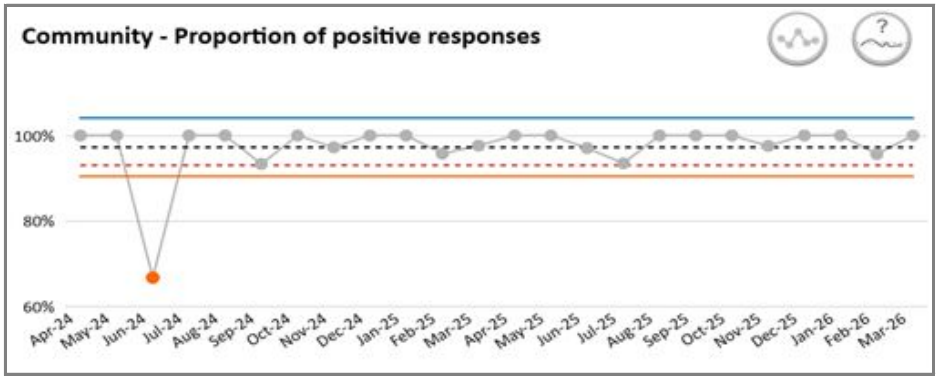
Quality

Friends and Family Test









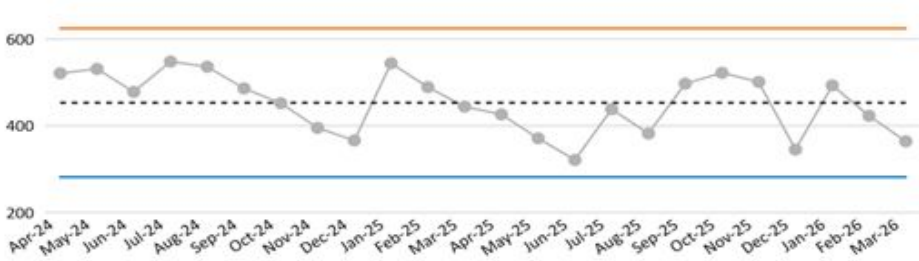
Month 12 | 2025-26

Quality

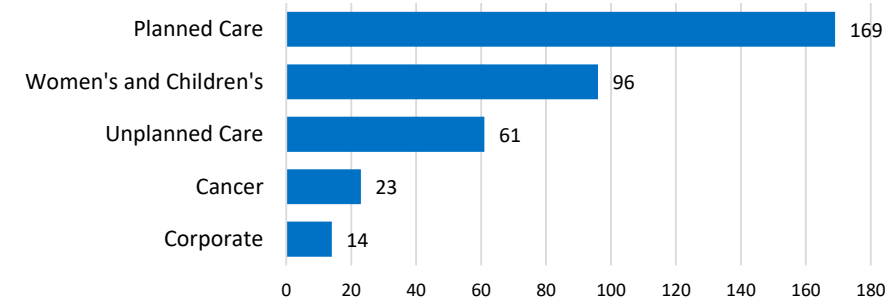
Patient Advice and Liaison Service

East and North Hertfordshire Teaching NHS Trust

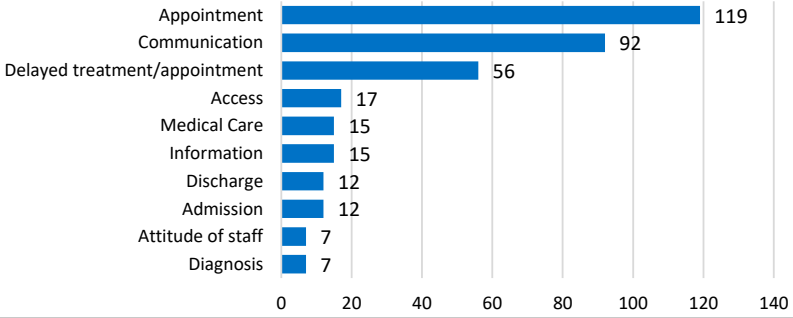
Number of PALS referrals



PALs by Division - Mar-26



PALs Top 10 subjects - Mar-26

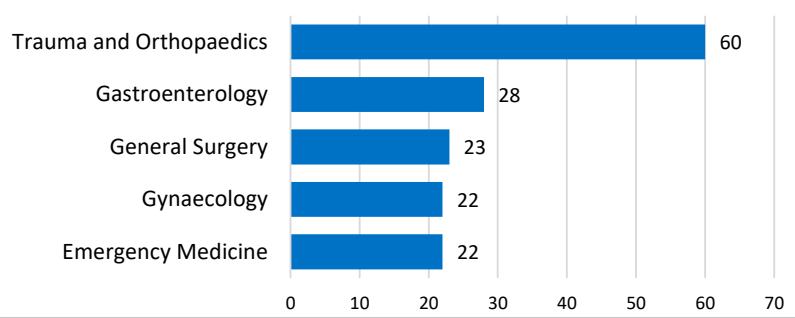


Key Issues and Executive Response

Patient Advice Liaison Service

- New PALS online form will be launched at the start of May. This allows patients/carers etc to log their enquiries straight onto ENHance. As such decreasing the amount of admin time for the PALS officers. Further communications internally and externally will be live in April.
- 387 PALS cases currently logged on Enhance with an additional 150 emails to review from March, increasing the monthly total.
- Concerns around appointment lines have been escalated to the Head of Digital patient services, as there has been a significant increase in appointment related concerns. PALS currently fielding many appointment queries / being used as an appointment line.
- Trauma and Orthoptics continue to have the highest enquires raised - all for waiting list updates and delay in appointments
- To note, the total number of raised concerns reported will considerably increase once all emails have been reviewed and logged in ENHance from March.

PALs Top 5 specialties - Mar-26

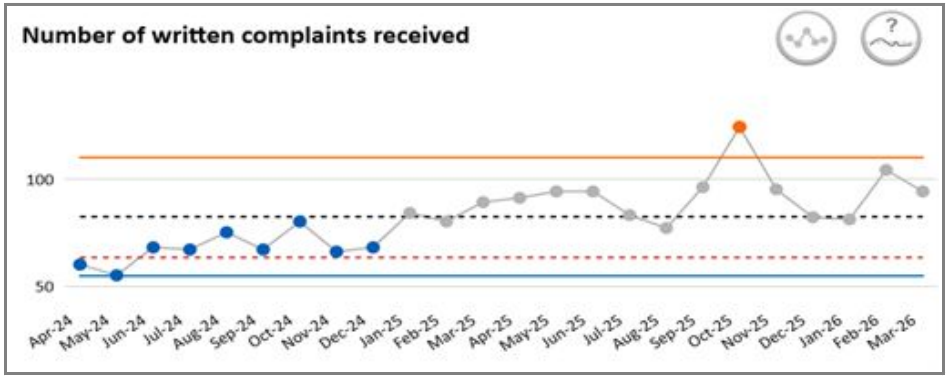


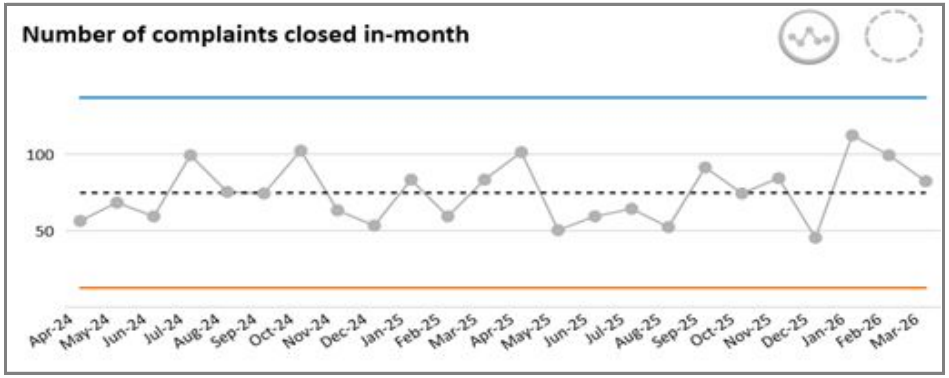
Month 12 | 2025-26

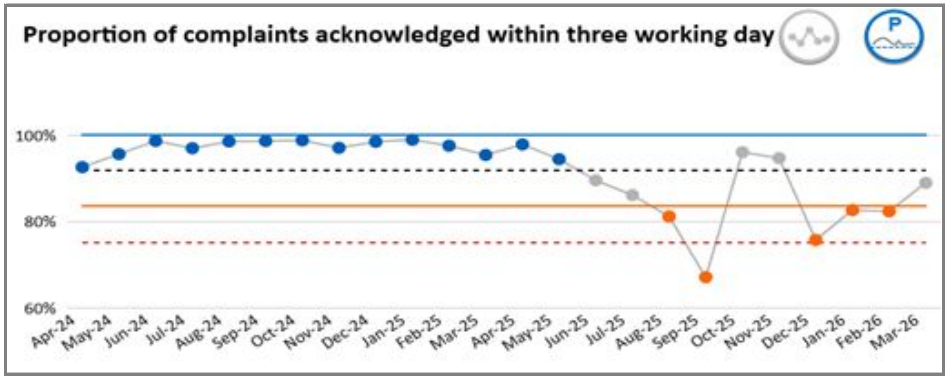
Quality

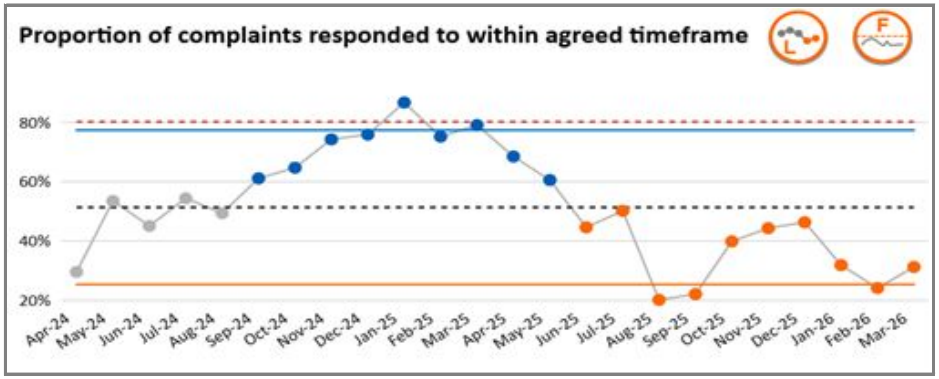
Complaints

NHS East and North Hertfordshire Teaching NHS Trust









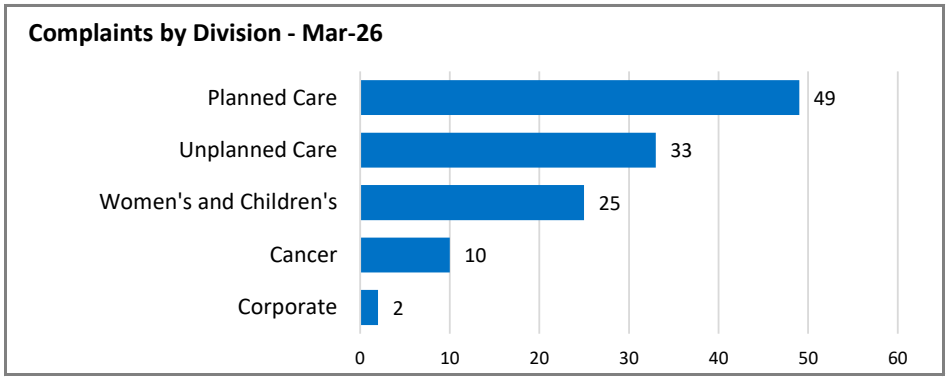
Key Issues and Executive Response

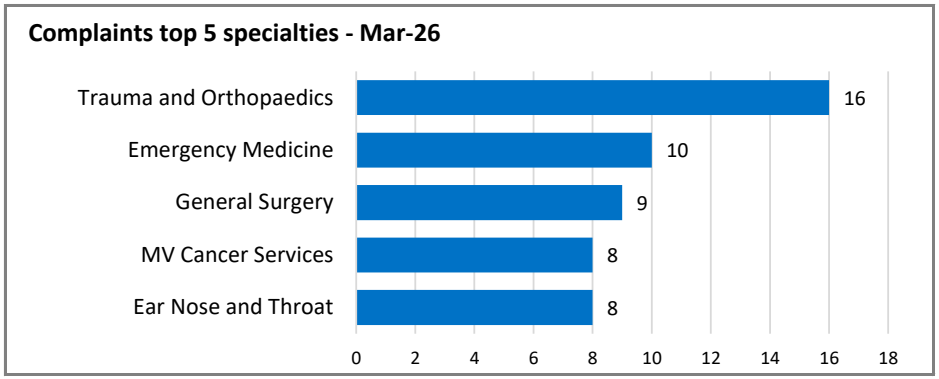
- A discussion with the BI team reviewing the data clarified that the IPR data shows the complaints under investigation. ENHance data incorporates complaints awaiting scope into the figures, whereas the BI numbers do not as they are not currently under investigation, resulting in reporting disparity - now resolved.
- There was a slight rise in the number of complaints received in March 2026 - 130 compared to 126 received in February 2026.
- However a significant number of complaints have been closed in March 2026 - 102 with a focus on the oldest open complaints.
- Overdue action plans within the divisions remains high and further work needs to be done to reduce what is currently open.
- Planned Care continues to have the largest number of complaints open and raised during the month of March. The Division have been working closely with the complaints team to ensure the investigations are within the allocated timeframe.
- Complaints rising around appointments being escalated from PALS as patients unhappy with multiple cancellations and delays in getting appointments.

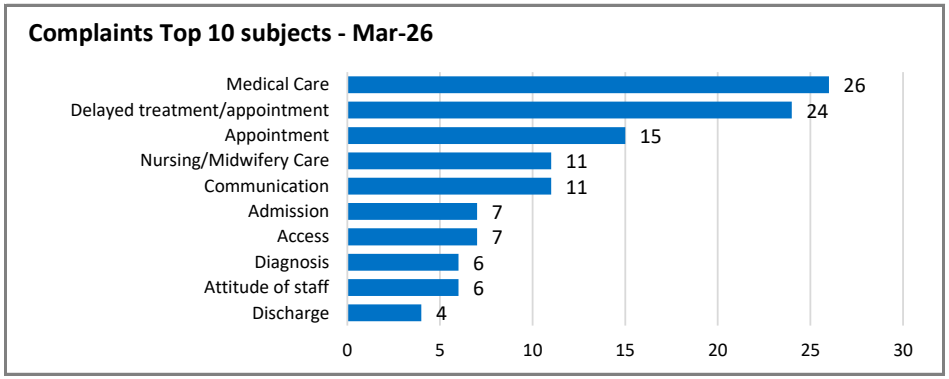
Month 12 | 2025-26

Quality

Complaints Themes





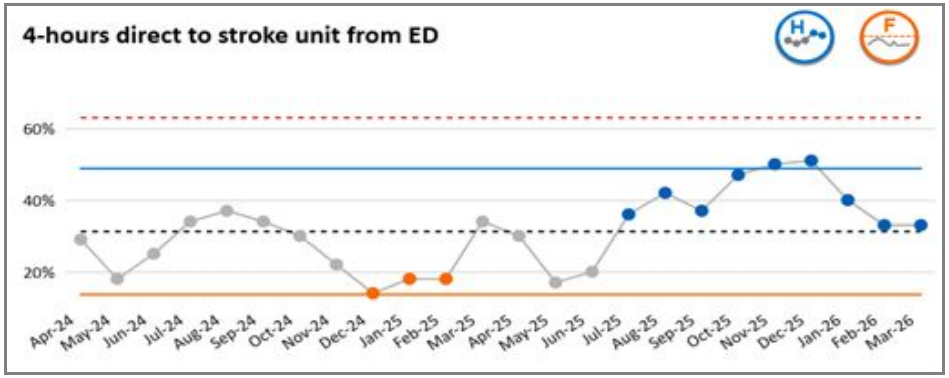


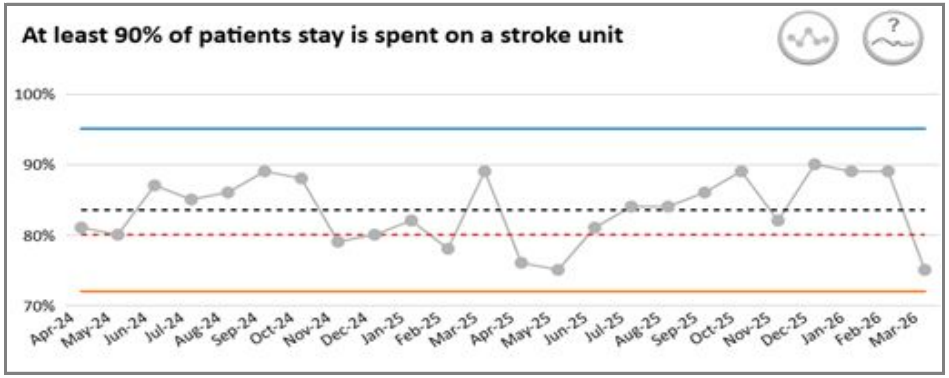
Month 12 | 2025-26

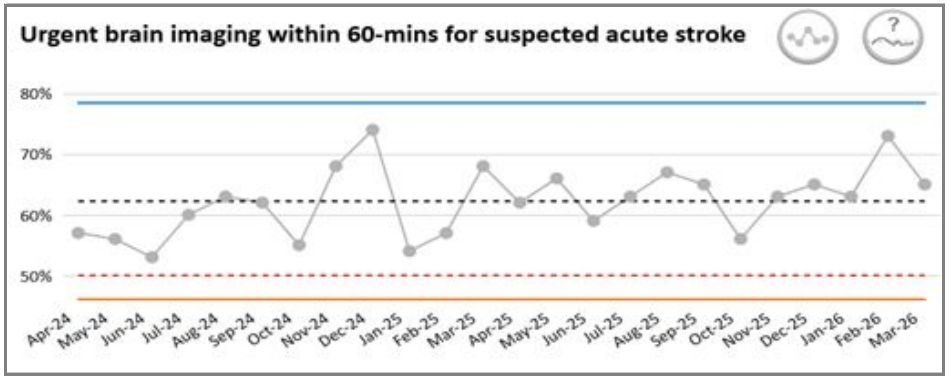
Operations

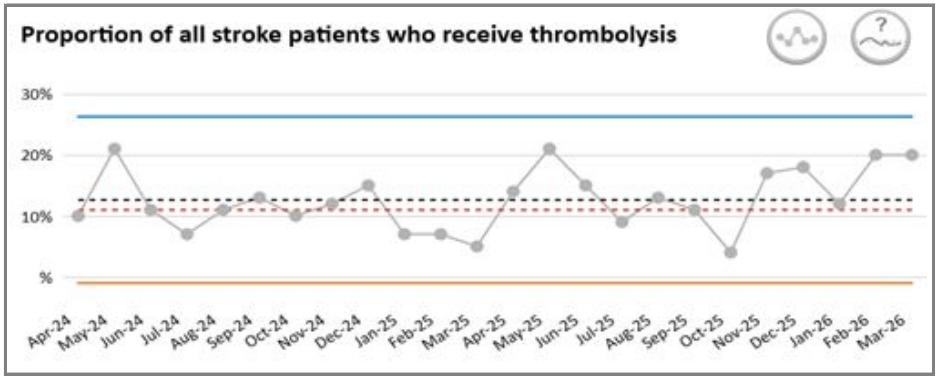
Stroke Services

NHS East and North Hertfordshire Teaching NHS Trust









Key Issues and Executive Response

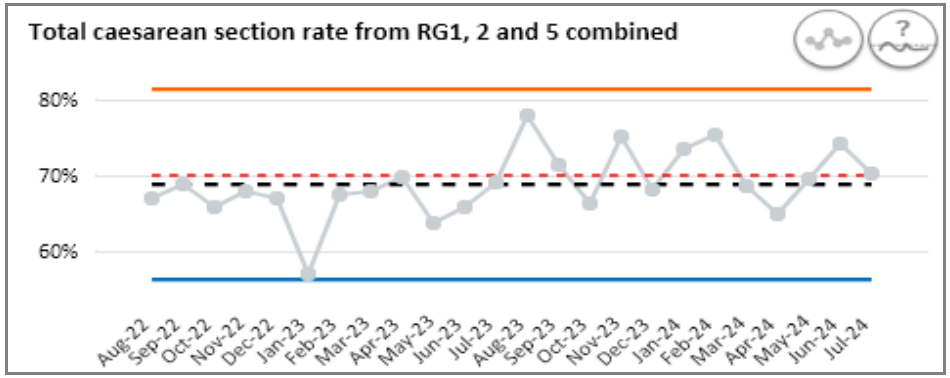
- **Thrombolysis/Thrombectomy -** Door to needle time 1:12 hr. Increase to 20% of patients receiving thrombolysis against bespoke 14% target. CTP 24/7 go live planned for beginning of May 26. Thrombectomy at 9.1% with 10% target - (16 referred, 10 sent, 7 performed).
- **4 hr performance 33.3%** for confirmed strokes. Q4 25 results = 52.1%. March saw a drop in performance due to significant MRI, rehab and non-stroke increase. SPC chart still displays positive upward trend. Influencing factors; SOP, SPR 7/7 2200 working, CTP, ward & CNS processes, weekly breach meetings/validation & stroke ward flow improvements.
- **Length of stay:** Increase in level 1 beds required which is impacting LOS. Ongoing discussions with ICS and region addressing capacity plans long term. MRI delays & repat out processes required to support flow.
- **CT within 20 minutes:** Significant improvement to 38% (national target of 40%). Implementation of Stroke Video Triage will improve rapid diagnosis with go live in house est. May 26 - pending senior clinical decisions.
- **TIA performance:** 24hr standard at 3.5 days. Improvements due to in-house process changes, collaborative working with radiology with increase in Doppler slots plus pathway changes in referral process from GP's into TIA. Slight delay due to IA strikes.

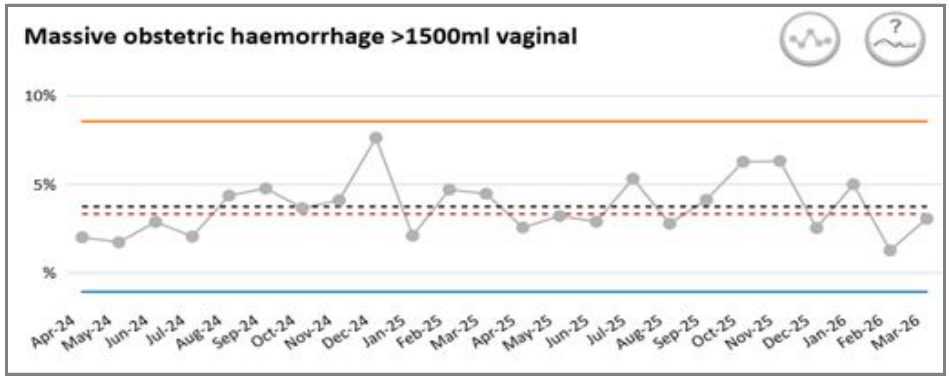
Month 12 | 2025-26

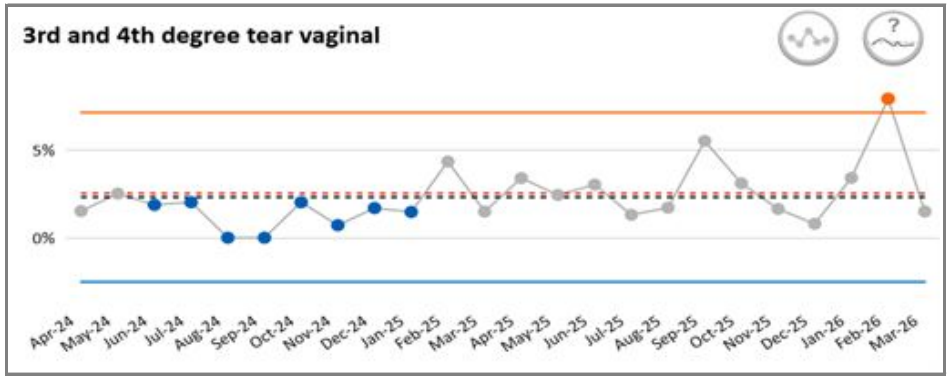
Quality

Maternity | Safety Metrics

East and North Hertfordshire Teaching NHS Trust







Key issues and executive response

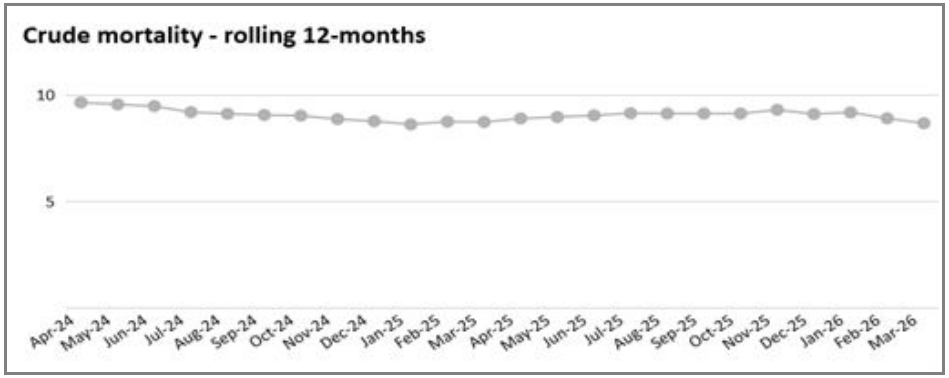
- There was one case referred to the MNSI but has since been rejected by MNSI for patient request and EEG and MRI associated with positive outcome. The case was stepped down as PSII for the Trust at PSERP.
- There were five cases of moderate physical harm (2% of 212 incidents reported), consistent with previous months. One unavoidable admission to the neonatal unit (ATAIN) late admission in labour, swift cat LSCS (rejected MNSI case), one avoidable ATAIN for delays in transfer to theatres due to acuity, and three cases of MOH >2000mls, one requiring four units of blood. MOH element 5 of NHSE Maternal Care Bundle launch for monthly divisional oversight on improvements.
- Increasing number open and overdue incidents (up to 212 from 167 Feb 2026 and 137 Jan 2026). All have commenced learning response and patient engagement. Reports awaiting final actions prior to closure. There was one case of intra-uterine death >22/40, one case of early neonatal death >20/40 and no cases of maternal death. All relevant cases are reported via MBRRACE and reviewed via PMRT.
- There was a significant reduction in overall rates of 3rd/4th degree perineal trauma, but rates at instrumental births remained high at 8.00 %(reduced from 13.64% Feb 2026). Working party established to ensure MDT thematic review and progress on actions including training and OASI care bundle). Benchmarking for learning to take place on NHSR Thematic review of OASI with claims report.
- Rates of both ATAIN and MOH have improved on previous months.
- Total LSCS= 169 (47.88%), total Cat 1-3 (Emergency) = 80 (22.66%), total Cat 4 (Elective) = 89 (25.21%) reflective of an increasing LSCS birth rate nationally. Emergency rate may be reported higher than actual as elective cases moved to cat 3 lists due to capacity. Robson Group Criteria RC1 = 26.31%, RC2 = 68.91%, RC5 = 78.57%.

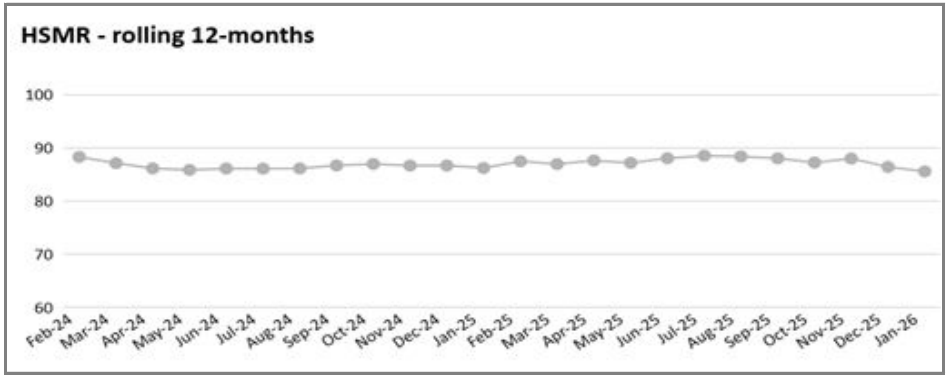
Month 12 | 2025-26

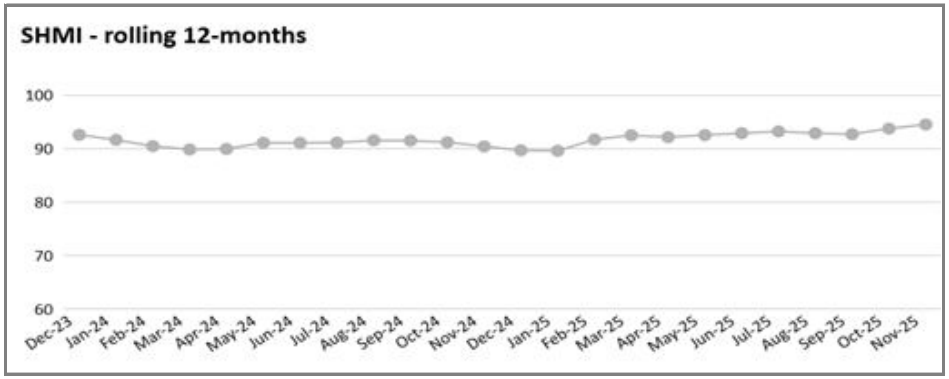
Quality

Mortality

East and North Hertfordshire Teaching NHS Trust







Key Issues and Executive Response

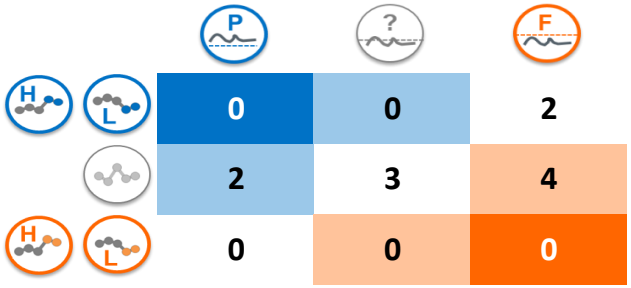
- Crude mortality is the factor which usually has the most significant impact on HSMR. The exception was during the COVID pandemic, when the usual correlation was weakened by the partial exclusion of COVID-19 patients from the HSMR metric. This partial exclusion continues for the CHKS HSMR metric that the Trust uses.
- The general improvements in mortality (excluding the COVID-19 period) seen over recent years have resulted from corporate level initiatives such as the learning from deaths process and focussed clinical improvement work. Of particular importance has been the continued drive to maintain a high standard of clinical coding.
- There was a significant downward trend in rolling 12-month HSMR from March 2023 to April 2024, when the metric plateaued and had then been on an upward trend since January 2025. From July 2025 this trend has reversed.
- The latest rolling 12-month HSMR to Jan-26, reported by CHKS, stands at 85.5. This positions us in the mid-range of trusts nationally.
- Since the Jul-25 spike in in-month HSMR of 108.67, levels have reduced. The latest in-month figure for January stands at 75.7.
- Latest NHSD published rolling 12-month SHMI available to November 2025, stands at 94.44 an increase from the last month's 93.32. This positions us within the 'as expected' band 2.
- There has been a gradual negative shift in our position nationally, with currently positioned 37/118 vs other acute trusts (best position 18/118).
- The latest figures provided by CHKS for Oct-25 are 98.9 in-month and 93.3 for rolling 12-month. CHKS has reported that the recent increases have been largely driven by increases to out-of-hospital SHMI deaths rather than in-hospital deaths.

Month 12 | 2025-26

NHS
East and North Hertfordshire Teaching
NHS Trust

Operations

Month 12 | 2025-26



Urgent and Emergency Care

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	Mar-26	95%	74.7%		F	Common cause variation Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	Mar-26	5%	7.9%		?	Common cause variation Metric will inconsistently pass and fail the target
	Percentage of ambulance handovers within 15-minutes	Mar-26	65%	23.6%		F	Common cause variation Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Mar-26	80%	46.5%		F	Common cause variation Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Mar-26	240	184		P	Common cause variation Metric will consistently pass the target
	Average (mean) time in department - admitted patients	Mar-26	tbc	432			Common cause variation No Target
	Average minutes from clinically ready to proceed to departure	Jan-26	tbc	104	L		8 points below the mean No target
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Mar-26	92%	69.1%	H	F	5 points above the upper process limit Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Mar-26	0%	49.0%	L	F	7 points below the mean Metric will consistently fail the target

Month 12 | 2025-26

Urgent and Emergency Care

Summary

NHS East and North Hertfordshire Teaching NHS Trust

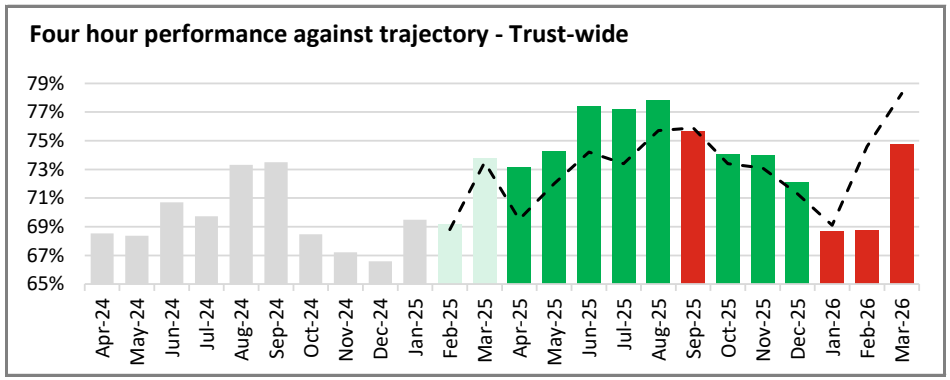
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	62-day referral to treatment standard	Feb-26	85%	82.6%			Common cause variation Metric will consistently pass the target
	31-day decision to treat to treatment standard	Feb-26	96%	97.2%			Common cause variation Metric will inconsistently pass and fail the target
	28-day Faster Diagnosis standard	Feb-26	75%	76.8%			Common cause variation Metric will inconsistently pass and fail the target
	Proportion of cancer PTL waiting more than 62 days	Mar-26	7%	22.2%			Common cause variation Metric will consistently fail the target

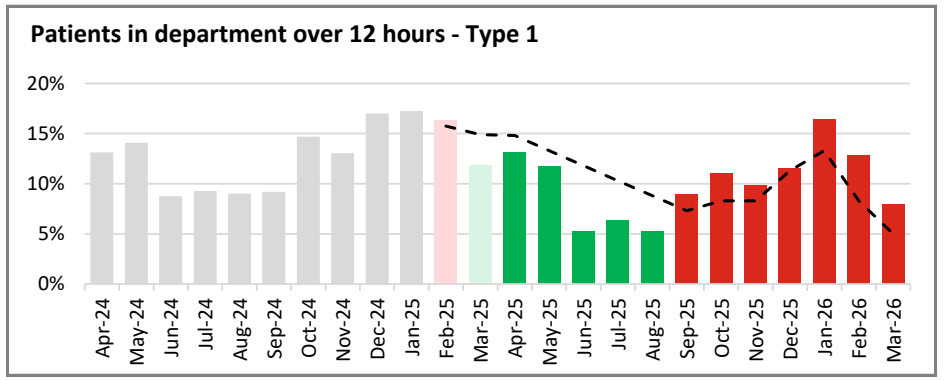
Month 12 | 2025-26

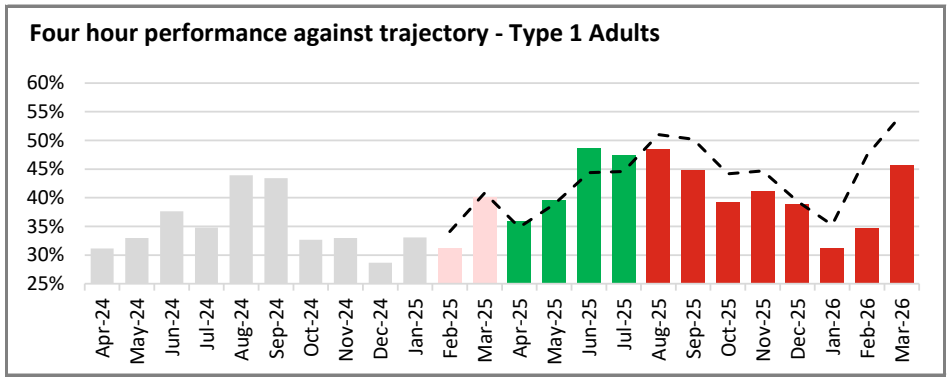
Urgent Emergency Care

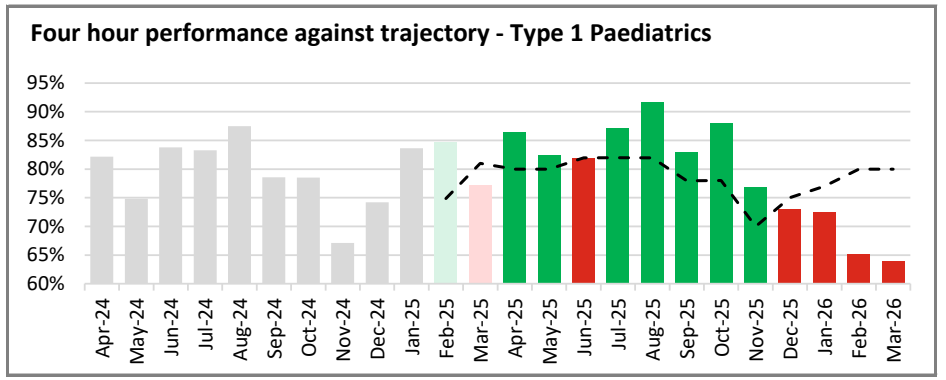
Trajectory Monitoring 2025-26

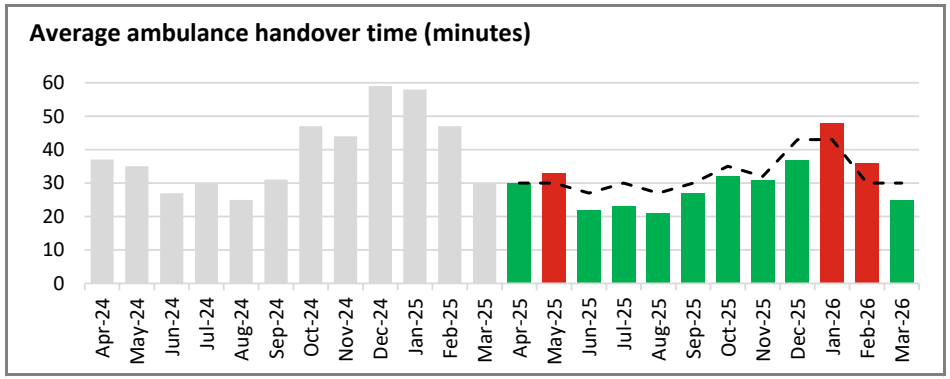
NHS East and North Hertfordshire Teaching NHS Trust









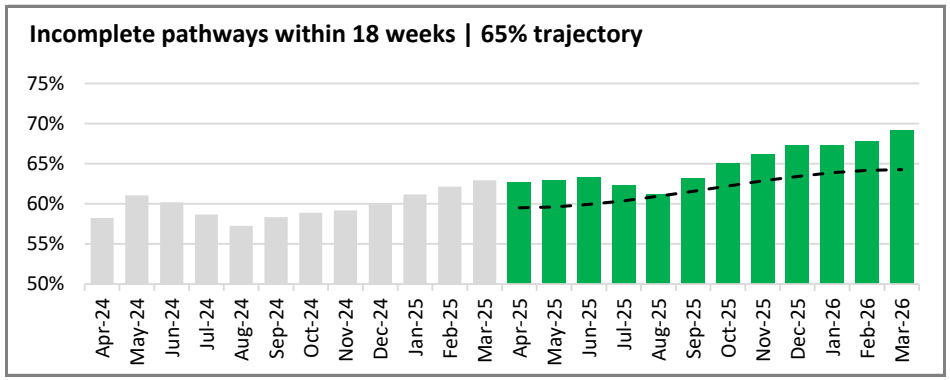


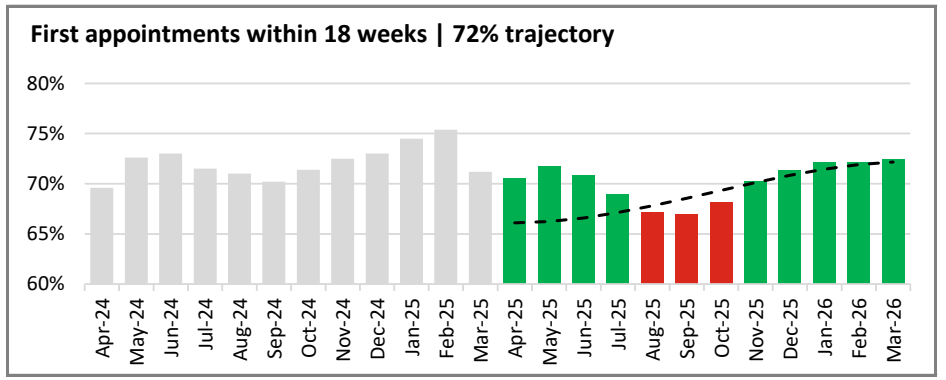
Month 12 | 2025-26

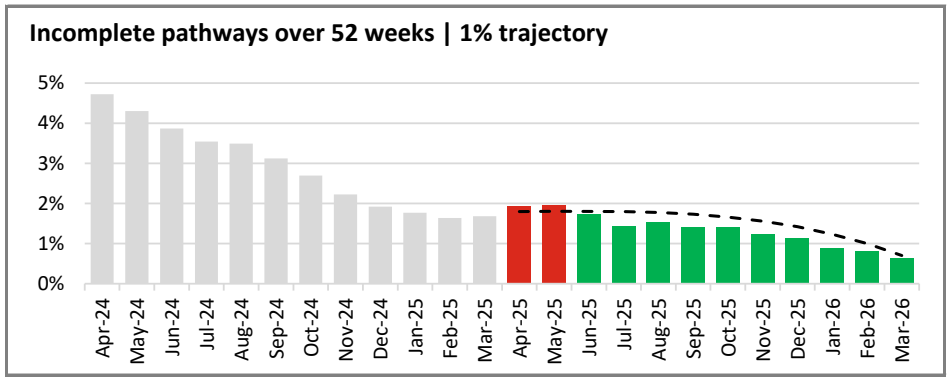
Cancer Waiting Times | RTT 18 weeks

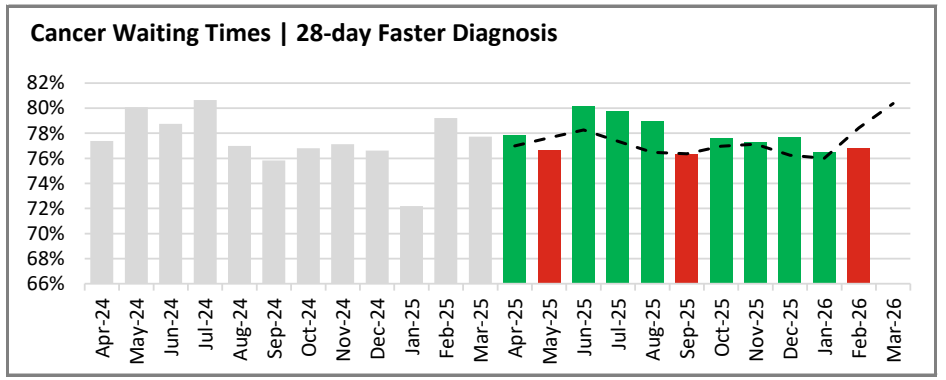
Trajectory Monitoring 2025-26

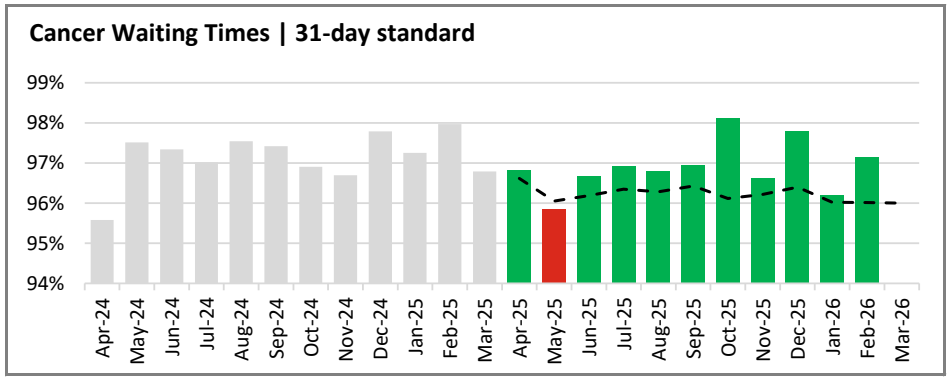
NHS East and North Hertfordshire Teaching NHS Trust

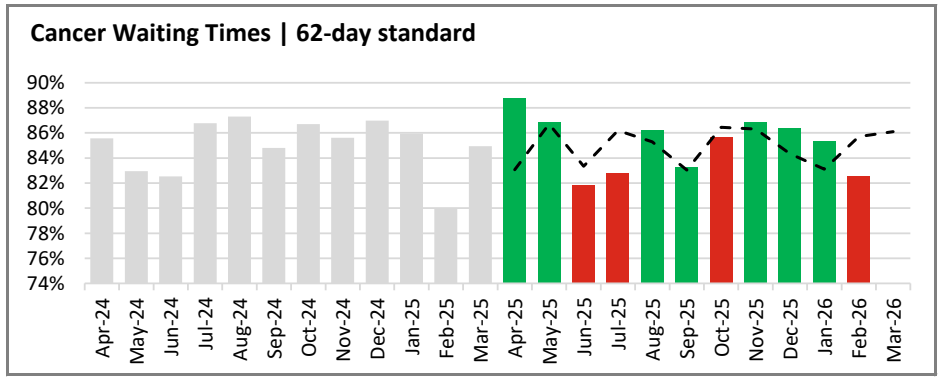










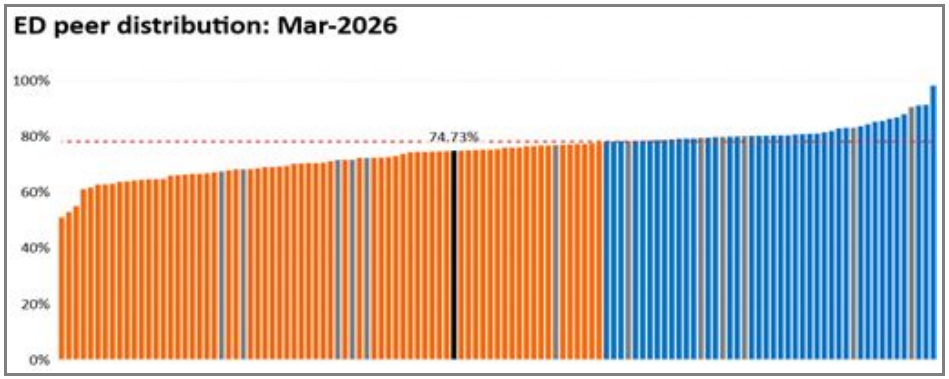


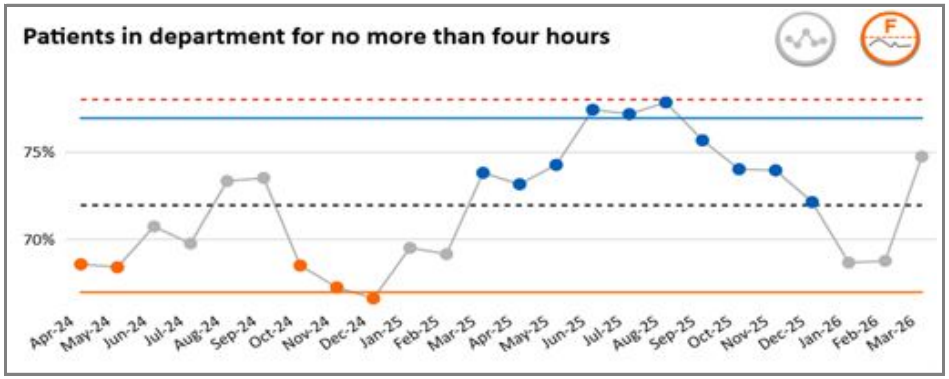
Month 12 | 2025-26

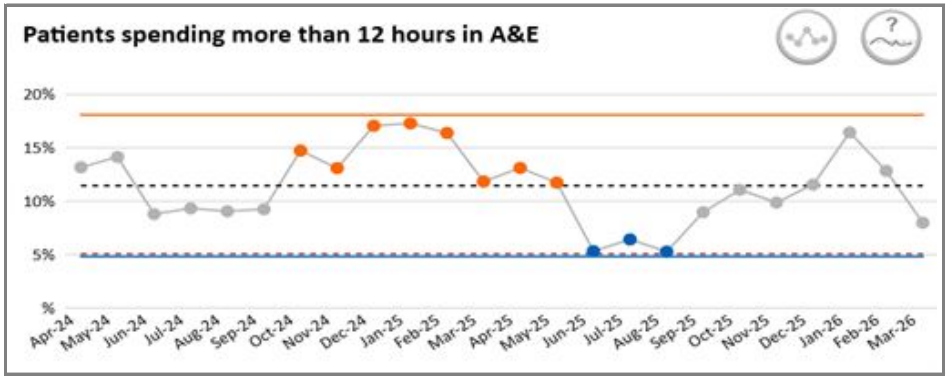
Operations

Urgent and Emergency Care New Standards

NHS
East and North Hertfordshire Teaching NHS Trust

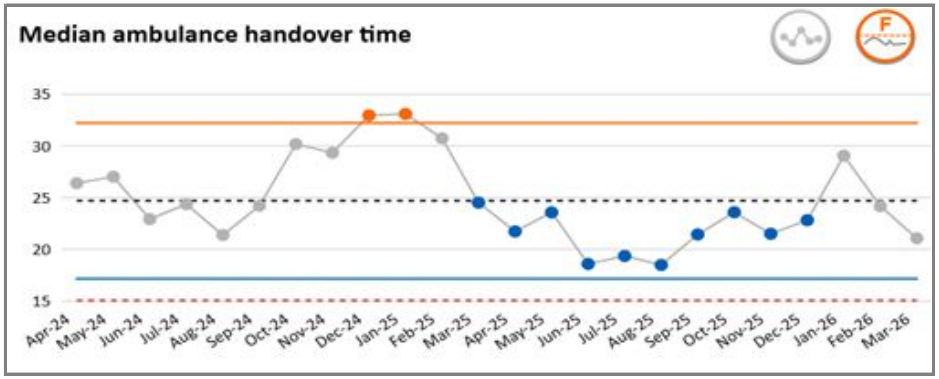






Key Issues and Executive Response

- In March-26, 4-hour performance was 74.7%, below trajectory of 78.3%. However, performance was the best since Sep-25 and was 0.9% better than Mar-25
- An improvement reset started on 1 March, focusing on direct streaming pathways across all services, optimising Acute Medical services and SAU flow. Now focussed into 3 programmes: adult med, adult surge and paeds, with Transformation support and CNO SRO, to drive further continuous improvement.
- March-26 saw increases in UTC and Paeds attendances. Paeds attendances were 3.7% higher than Mar-25 and adult attendances were 0.8% higher than Mar-25
- Adult Type 1 non-admitted performance was 53.4%, a 5% improvement from March '25 and 12% improvement from Feb '26. Adult Type 1 admitted performance was 25%, 8% improved from March '25 and 11% improvement from Feb 2026.
- Type 1 ED 12-hour waits stood at 7.93% vs a trajectory of 5% however a 3.86% improvement to March 25.
- Mean ambulance handover time was 25 minutes, a 5 min improvement from March 25 and 11 mins improvement from February.

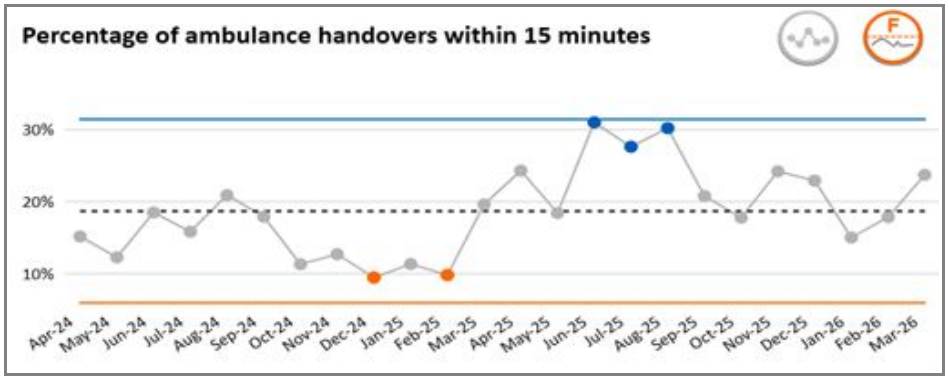


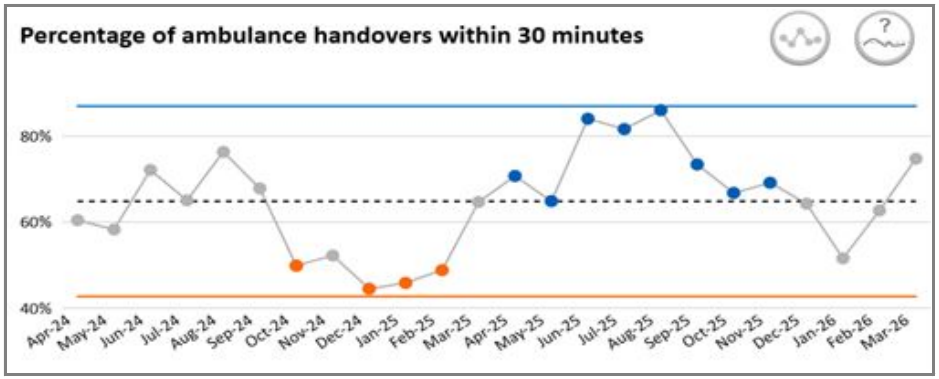
Month 12 | 2025-26

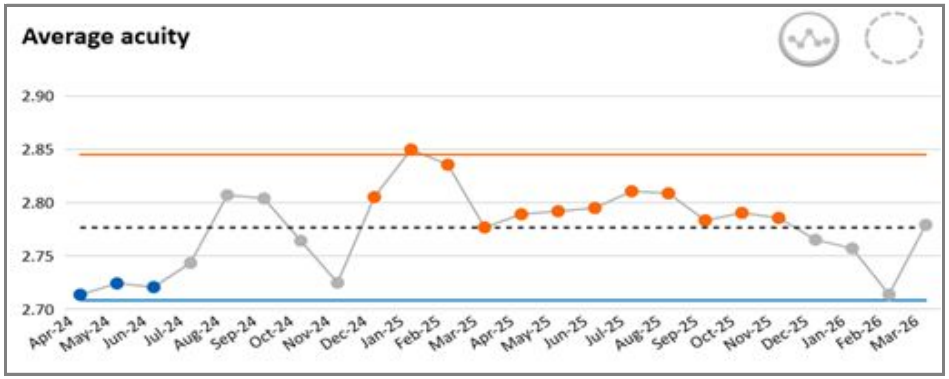
Operations

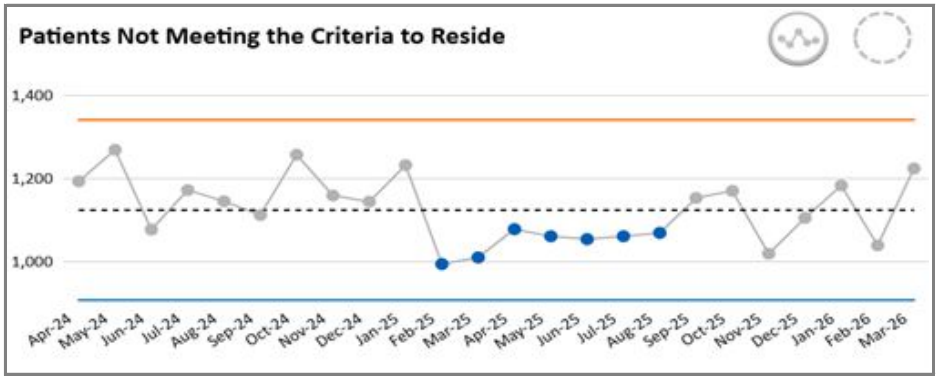
Urgent and Emergency Care | Supporting Metrics

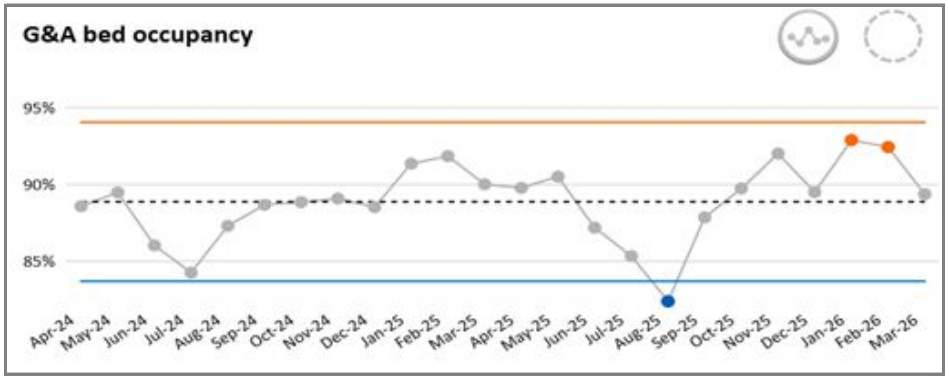
NHS
East and North Hertfordshire Teaching NHS Trust

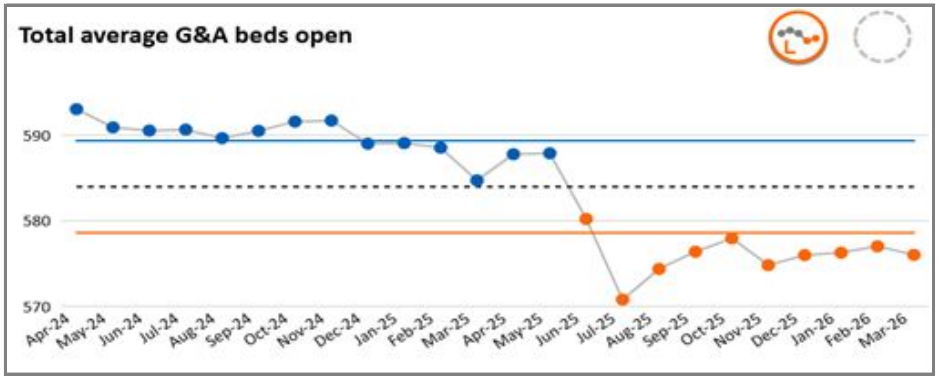










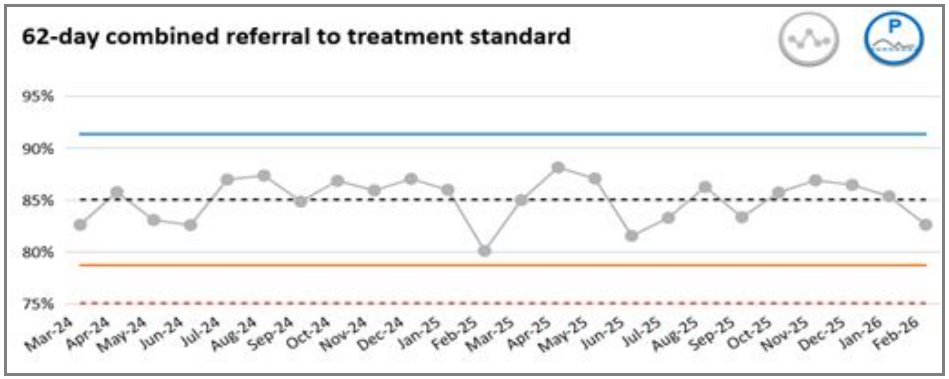


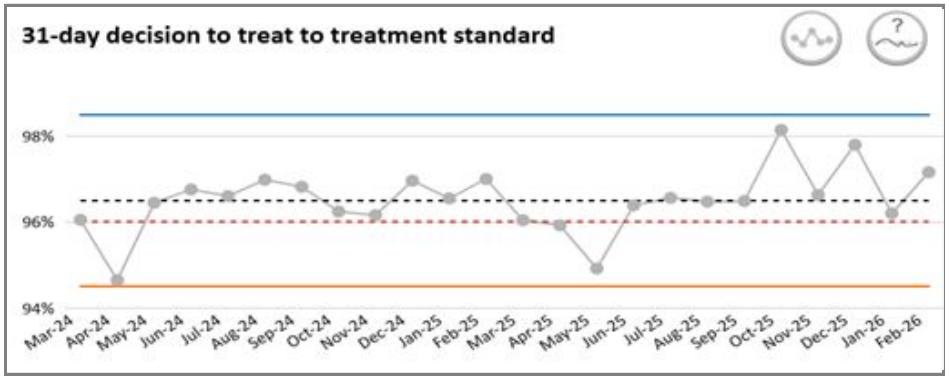
Month 12 | 2025-26

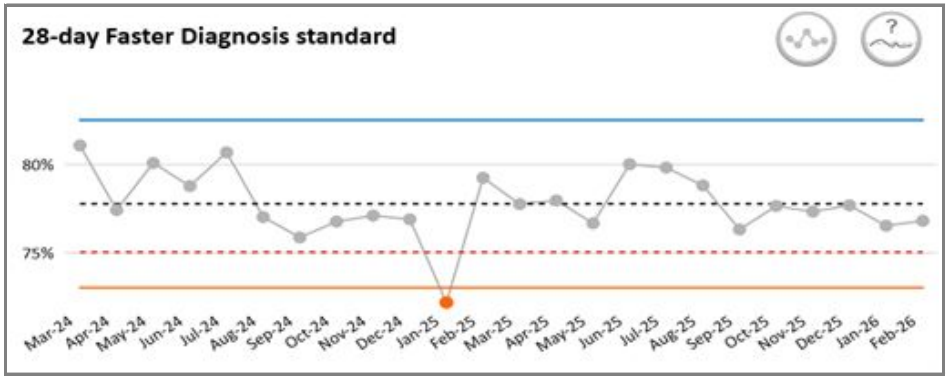
Operations

Cancer Waiting Times | Supporting Metrics

NHS East and North Hertfordshire Teaching NHS Trust







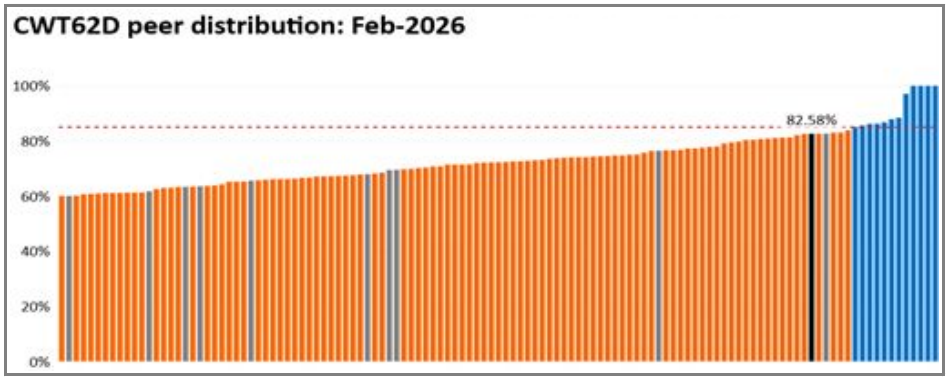
Key Issues and Executive Response

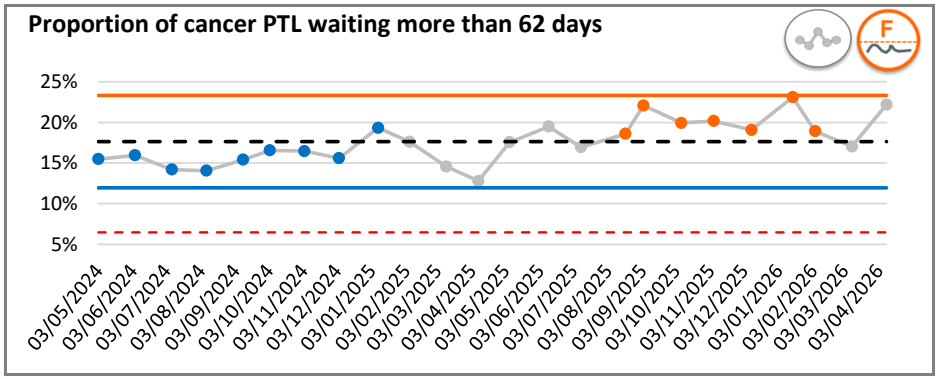
- We achieved 2 of the 3 national standards in February '26 with compliance in the 28 day Faster Diagnosis and 31 day decision to treat standards.
- We are working with the radiology team to reduce delays in MRI and CT colonoscopy capacity, with the aim of improving our 28-day FDS performance and staying on track with the planned trajectory.
- The 62-day referral-to-treatment standard was not met in February, with performance at 82.6%. Year-to-date aggregate performance stands at 85.1%.
- Five pathways mainly driving the non compliance: Lower GI due to CT colon capacity, partially mitigated with introduction of radiographer lists; Haematology due to complex investigation pathways; Urology due to MRI capacity delays, mitigating with using One Stop Health Care started on 16/3, offering 65 scans per week. Gynae due to hysteroscopy capacity, partially mitigated with additional lists and converting routine slots for 2ww patients. Seasonal variation following the Christmas holidays, with patient choice contributing to delays in the diagnostic pathway.
- The 62-day performance in January ranked 11th nationally out of 119 NHS providers. This exceeded both regional and national averages by approximately 15%, and we maintain the top-performing hospital in the East of England region.
- Work continues to sustain and improve CWT performance for the Trust: pathway and breach analysis to identify constraints and minimise delays; robust PTL management with clear escalations; and Demand and Capacity work to identify gaps in services.
- Breach analysis continues for all patients against all standards to influence pathway redesign and learning with MDT teams.

Month 12 | 2025-26

Operations

Cancer Waiting Times | Supporting Metrics





Month 12 | 2025-26

Operations

RTT 18 Weeks

NHS East and North Hertfordshire Teaching NHS Trust

RTT peer distribution: Feb-2026

Key Issues and Executive Response

Community Paediatrics

- Community Paediatrics is now reported via the Community Data Set. Referrals have started to stabilise since spring 2024, albeit at approx. 90 referrals per month higher than core capacity, so the waiting list continues to increase, with high numbers tipping across 104ww.
- Internal pathway improvements are starting to deliver additional capacity, with 3 pathway improvement pilots started in November. A review will be undertaken by the clinical director to evaluate and scope embedding these pathways as part of our BAU.
- System workstream via 3 COOs (ENHT, HPFT, HCT) accelerating delivery of next steps on shared Herts CYP ND service, including Proof of Concept assessment programme now in preparation.
- Single point of referral for neurodiversity hosted at HCT is now live, improving completeness of information ahead of triage.
- Further improvements and the use of technology are being worked up, alongside improved signposting whilst waiting.
- **78 Weeks** - There were 3,579 patients waiting over 78 weeks at the end of March, a reduction compared to 3,609 the previous month.
- **65 Weeks** - There were 4,123 Community Paediatric patients waiting over 65 weeks, an increase from 4,095 at the end of January.

Key Issues and Executive Response

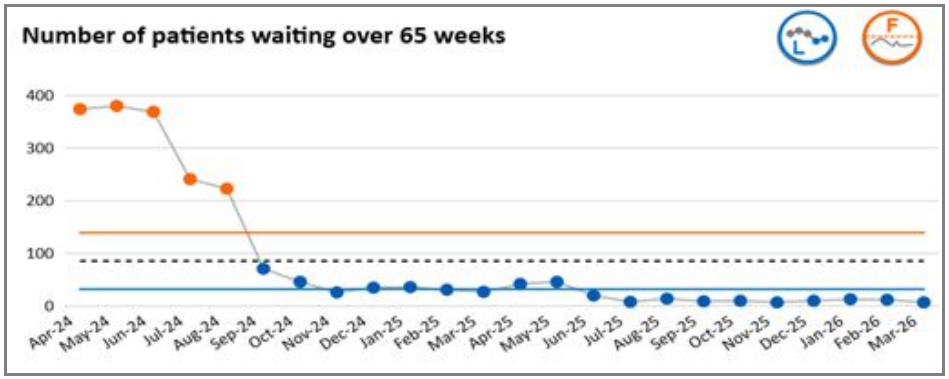
Excluding community paediatrics

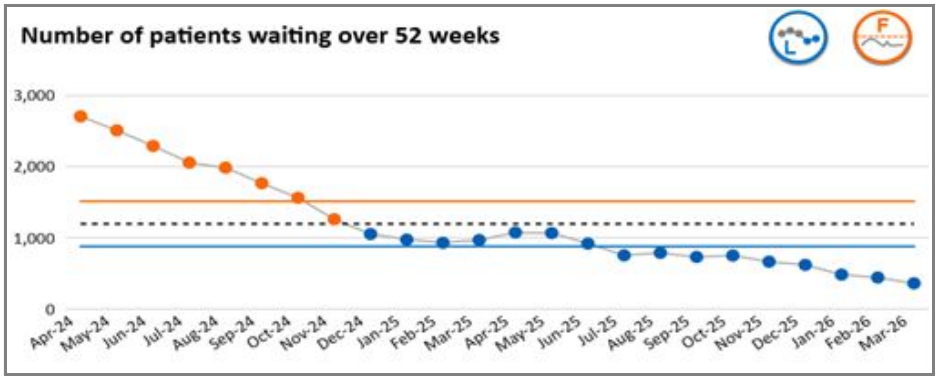
- **18 Week Performance** - We delivered 69.1% of patients waiting under 18 weeks at the end of March, exceeding the 5% improvement target of 64.2% for March 2026 by 5%; and also delivering the Q4 69% Sprint commitment.
- **52w proportion of PTL** - We delivered 340 patients / 0.62% waiting over 52 weeks at the end of March, meeting the end of year target of no more than 0.7% patients on 31 March 2026.
- **Awaiting First Event < 18 weeks** - We delivered 72.4% of patients waiting less than 18 weeks for their first activity, exceeding the March 2026 improvement target of 72.2%.
- The Patient Treatment List (PTL) has increased by 529 patients. Additional validation work taking place to address this.
- **65 Weeks** - At end of March, 6 patients were waiting over 65 weeks: 4 in Trauma & Orthopaedics (T&O), and 1 in Orthodontics and 1 in ENT. The breaches were due to clinical complexity, patient choice and patient fitness.

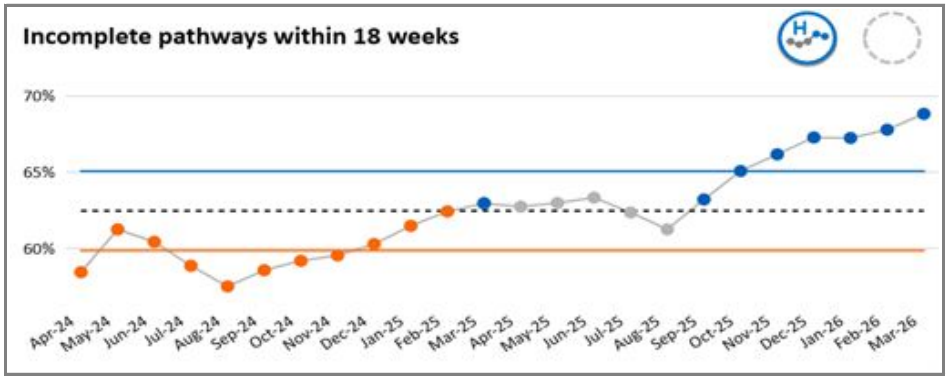
Month 12 | 2025-26

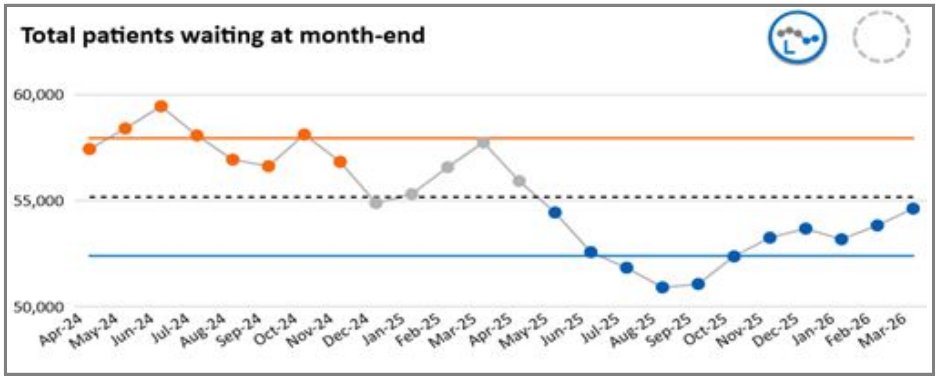
Operations

RTT 18 Weeks - excl. Community Paediatrics







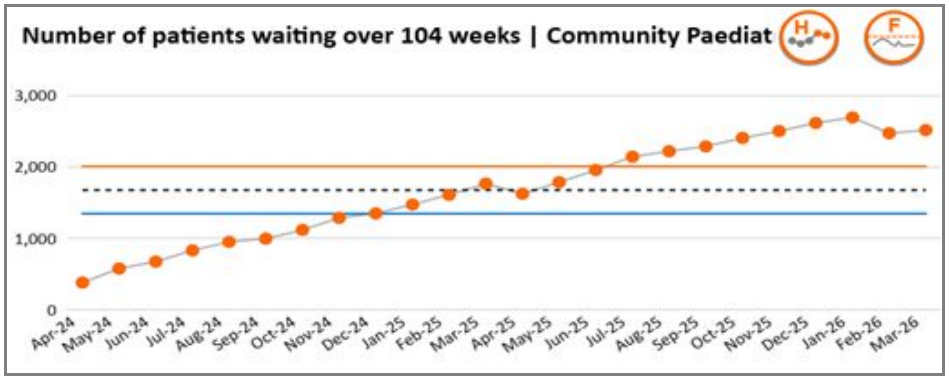


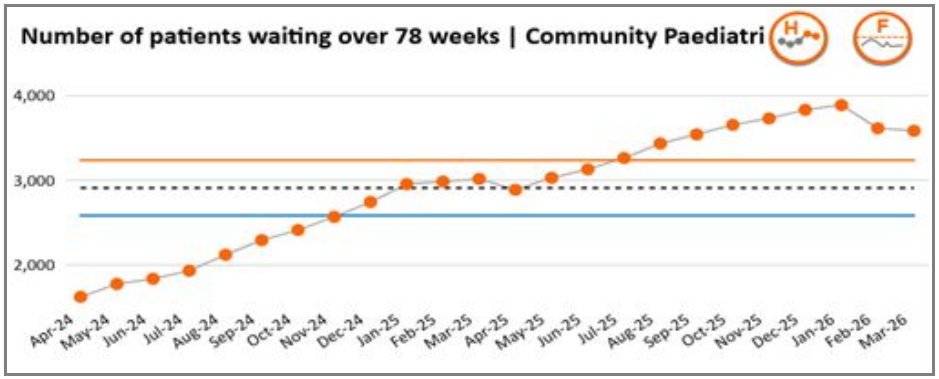
Month 12 | 2025-26

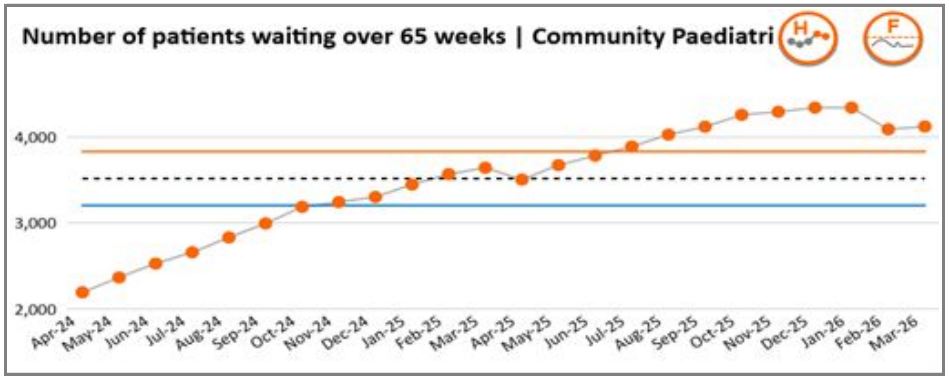
Operations

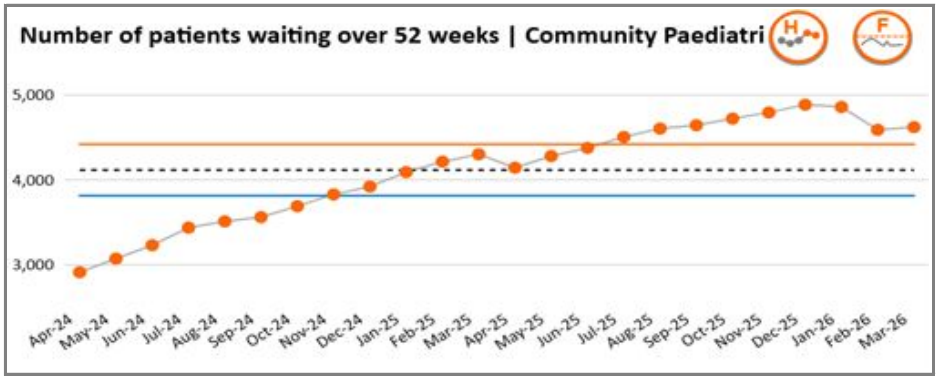
RTT 18 Weeks - Community Paediatrics ONLY

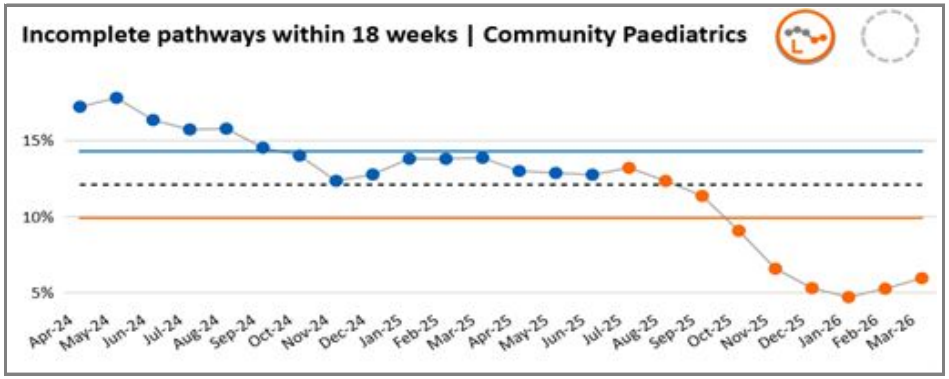
NHS
East and North Hertfordshire Teaching NHS Trust

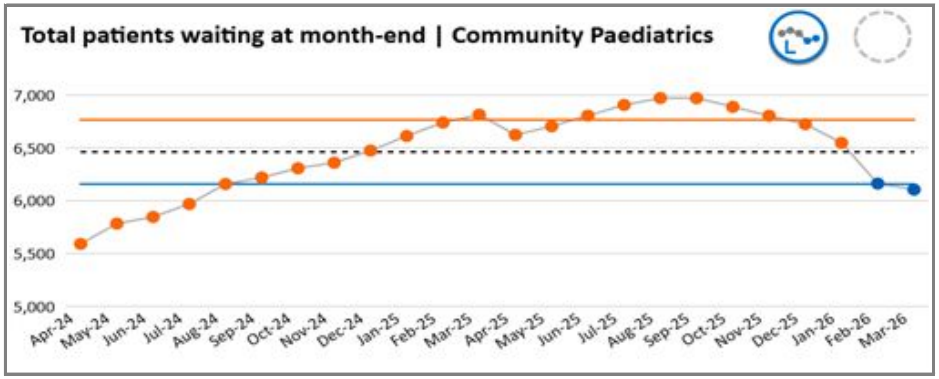










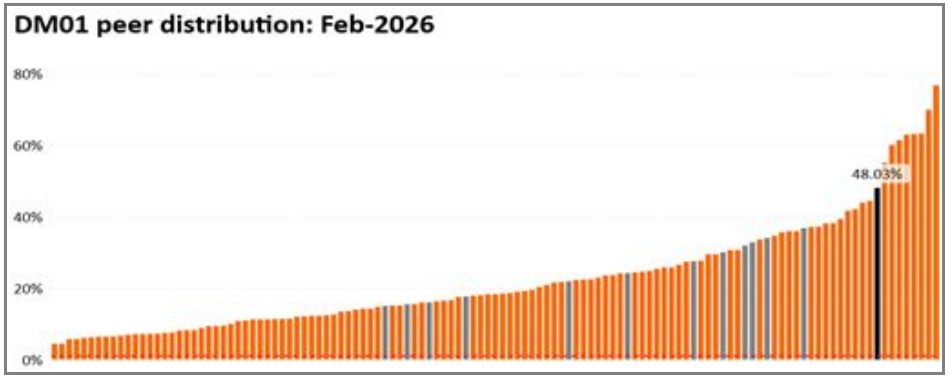


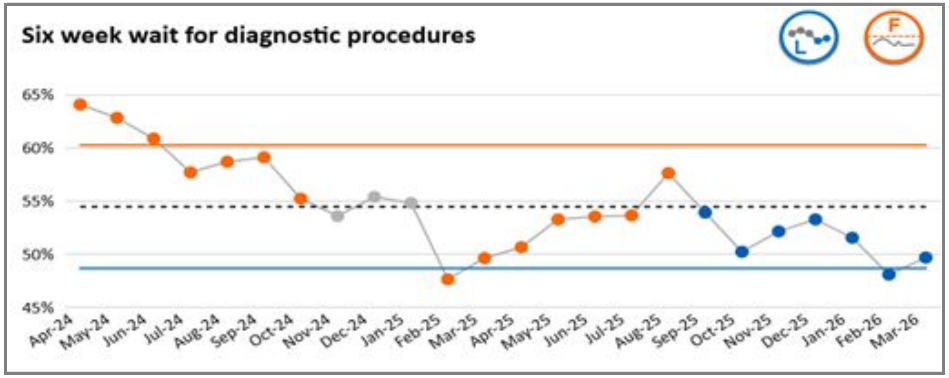
Month 12 | 2025-26

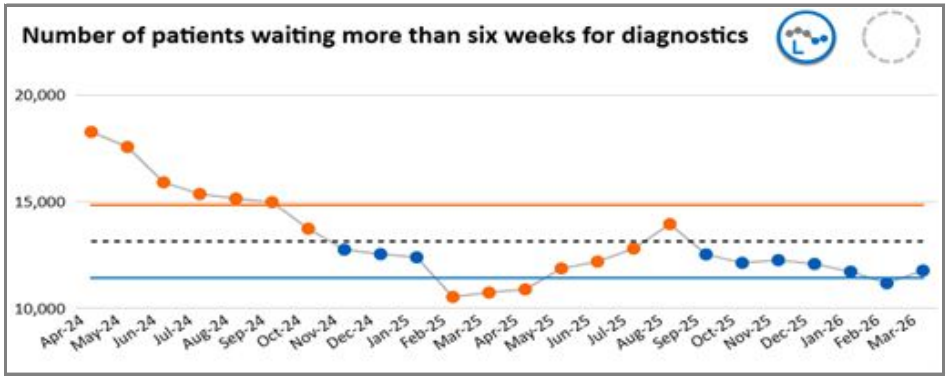
Operations

Diagnostics Waiting Times

NHS East and North Hertfordshire Teaching NHS Trust







Key Issues and Executive Response

- Last 6 months we have driven a positive shift in diagnostic waits over 6 weeks, both volume and percentage.
- In March, DM01 performance (% waiting over 6 weeks for diagnostics) slightly deteriorated from 48.03% to 49.04%.
- Excluding Audiology, there are 6,161 patients waiting >6 weeks; with 493 patients waiting >13 weeks, most waiting for MRI or US.
- Weekly escalation meetings are in place with services who are not compliant which follow the same rigour as RTT meetings.

Challenges / Actions

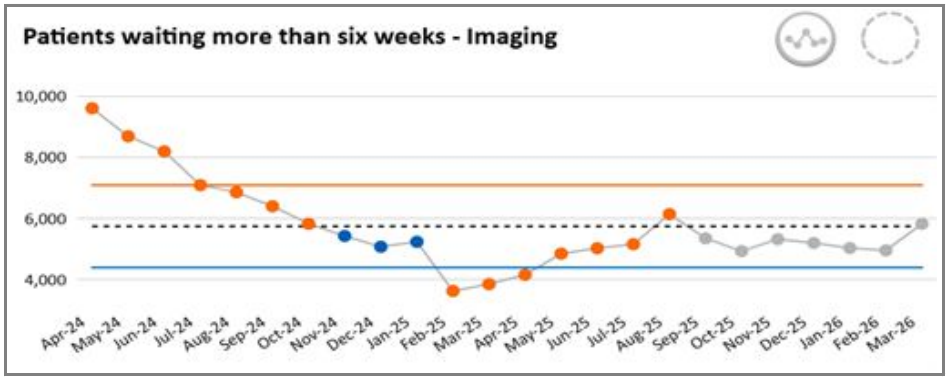
- **Non-Obstetric ultrasound** impacted by staffing gaps (20% vacancy, 5 wte out to ad); appointed two -1 started 9/2 and 1 started in March. Extension of insourcing agreed for 3 months. Launch of consultation for standardised shifts to deliver 6-day; 9-hour service to start 27/4. Current performance deteriorated from 35.6% to 39.4%, with breaches increasing from 3,064 in February to 3,502; mean wait improved to 4.79 weeks in March.
- Outsourcing of **MRI** activity to One Stop Health Care started 16/3: 65 scans per week. MRI van has been signed for 4 lists(16-20 per list) per week until Oct '26. Consultation on 7-day MRI service completed, implementation from 5 April. 6.38 wte out to ad. 1618 patients over 6 weeks; mean wait 5.82 weeks. Capital funds agreed to replace two MRI scanners in 26/27.
- Capital works for paeds **audiology** completing, planned to open by end 4/26. We plan DM01 compliance in paeds audiology by the end of 26/27, with a 5-10% improvement in performance each month. Adult audiology currently 86.87% (3,854 breaches) with mean wait of 45 weeks. Paeds currently 91.59% (1,415 breaches) with mean wait of 49.8 weeks.
- **Sleep studies** - New clinic locations in use at Lister; DNA % reduced.

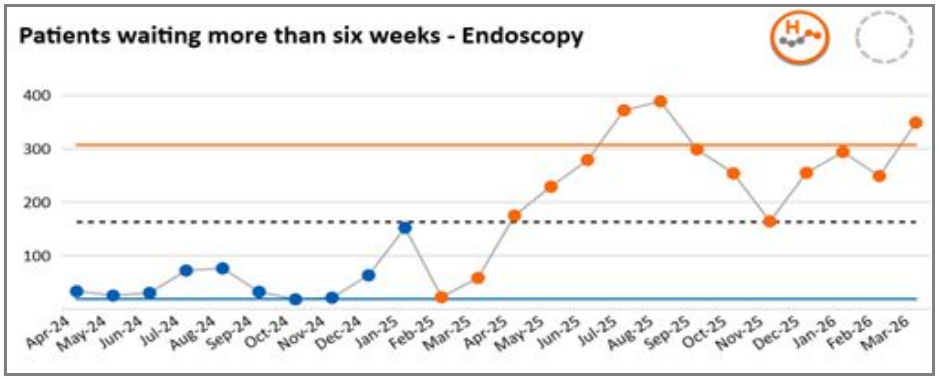
Month 12 | 2025-26

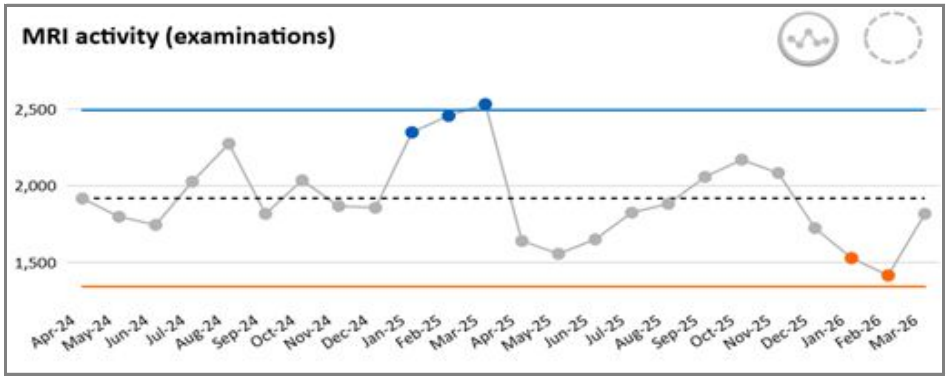
Operations

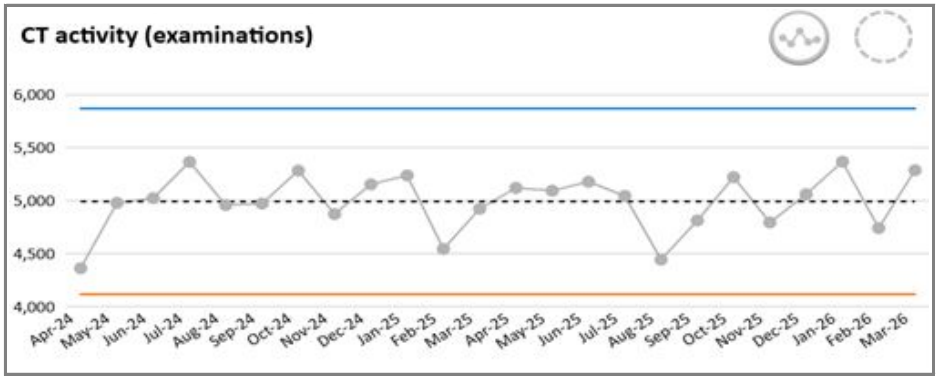
Diagnostics Waiting Times

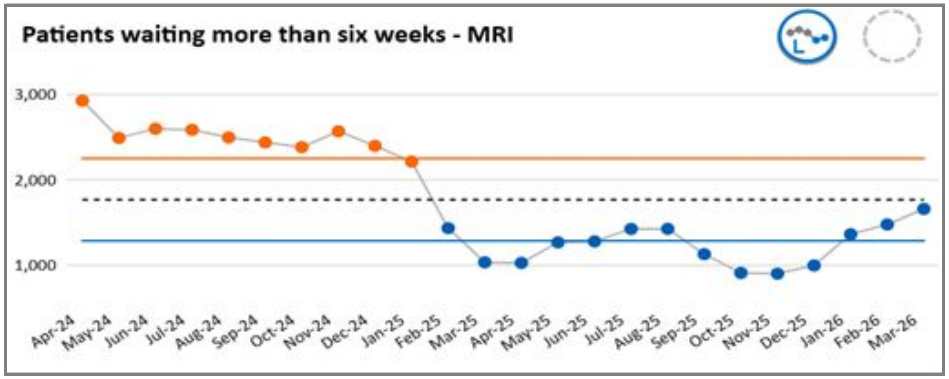
NHS East and North Hertfordshire Teaching NHS Trust

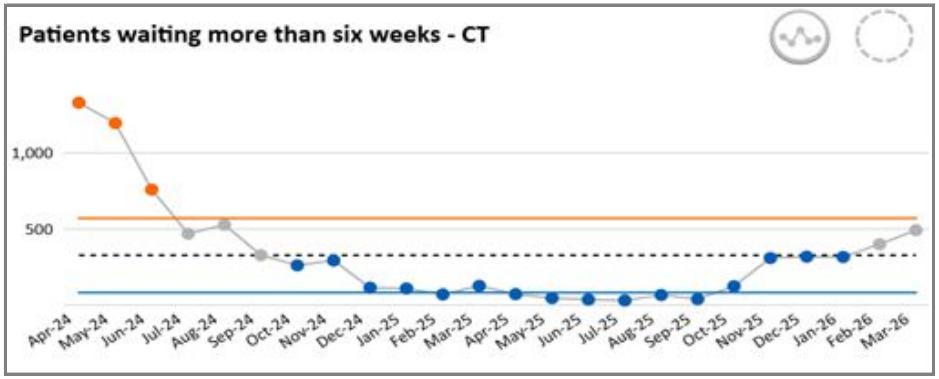












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NHS
East and North Hertfordshire Teaching
NHS Trust

Finance

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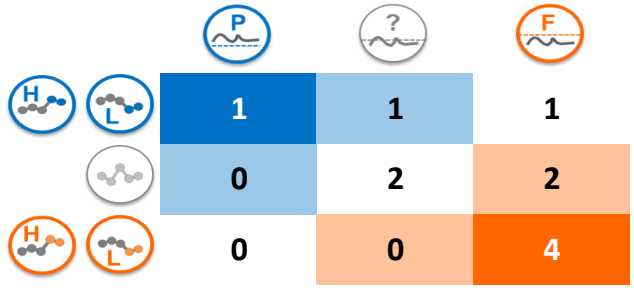

Finance

Summary

East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Mar-26	-2.4	8.28	H	?	1 point above the upper process limit Metric will inconsistently pass and fail the target
	CIPS achieved	Mar-26	1,245	2,999			Common cause variation No target
	Cash balance	Mar-26	77.9	41.3		F	Common cause variation Metric will consistently fail the target
Key Financial Drivers	Income earned	Mar-26	45.3	72.5	H	P	1 point above the upper process limit Metric will consistently pass the target
	Pay costs	Mar-26	29.5	38.1	H	F	12 points above the mean Metric will consistently fail the target
	Non-pay costs (including financing)	Mar-26	15.5	26.1	H	F	1 point above the upper process limit Metric will consistently fail the target

Month 12 | 2025-26

Finance

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	Mar-26	24.9	34.4			12 points above the mean Metric consistently fail the target
	Average monthly substantive pay costs (000s)	Mar-26	0.9	5.7			12 points above the mean Metric will consistently fail the target
	Agency costs	Mar-26		0.4			6 points below the lower process limit No target
	Unit cost of agency staff	Mar-26		10.9			Common cause variation No target
	Bank costs	Mar-26	3.7	3.2			Common cause variation Metric will inconsistently pass and fail the target
	Overtime and WLI costs	Mar-26	0.5	0.6			11 points below the mean Metric will consistently fail the target
Other Financial Metrics	Private patients income earned	Mar-26	0.4	0.6			Common cause variation Metric will inconsistently pass and fail the target
	Drugs and consumable spend	Mar-26	2.8	4.8			Common cause variation Metric will consistently fail the target

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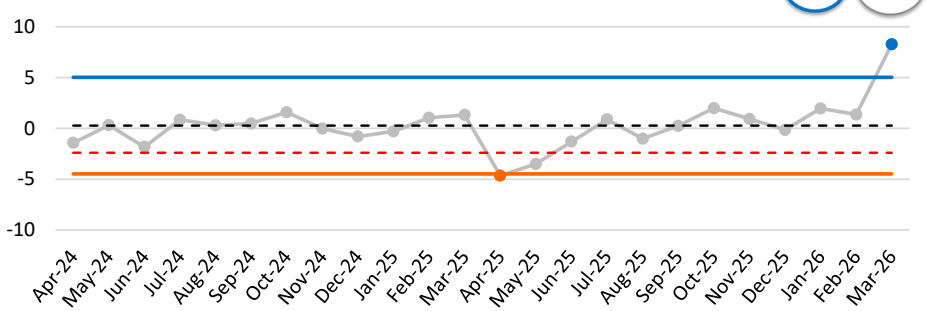
Finance

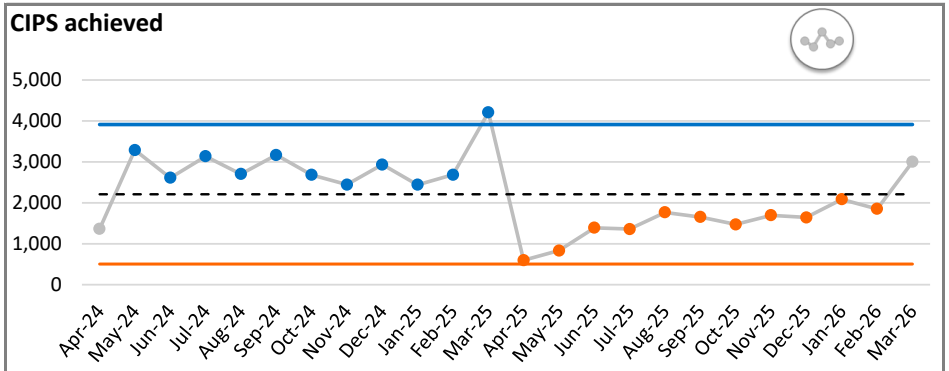
Summary Financial Position

East and North Hertfordshire Teaching NHS Trust

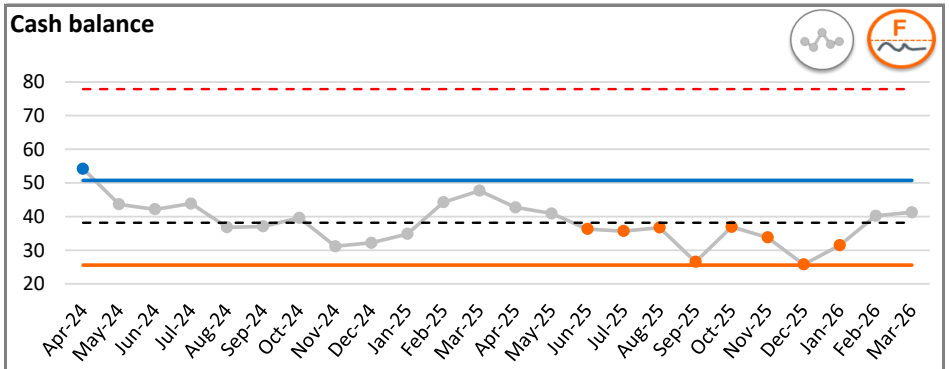
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

- The Trust reports a £5.0m surplus in line with plan at Month 12; however, delivery is heavily reliant on non-recurrent measures, including £4.9m deficit support funding, provision releases and balance sheet flexibilities. The underlying position remains materially adverse, reflecting a significant structural deficit.
- The primary drivers of this position are CIP under-delivery (£16.5m adverse), sustained workforce cost pressures—particularly within nursing—and continued misalignment between activity and expenditure. Divisional overspends persist across Unplanned Care, Planned Care and Women's & Children's, driven by demand, productivity constraints and unidentified savings.
- Elective performance remains below plan and this reflects underlying productivity challenges. Workforce growth has not translated into equivalent activity gains.

Executive Response

- The Executive recognises the structurally weakened financial baseline entering 2026/27 and the need for sustained improvement in recurrent performance. Actions are focused on:
- Resetting financial recovery with a clear focus on recurrent CIP delivery.
- Strengthening financial grip and cost control, including workforce and temporary staffing.
- Driving productivity improvement, particularly in theatres, beds and workforce deployment.
- Integrating financial and operational performance through strengthened governance.
- While the control total has been achieved, financial sustainability remains a key risk, requiring continued focus on recurrent improvement and reduced reliance on non-recurrent measures.

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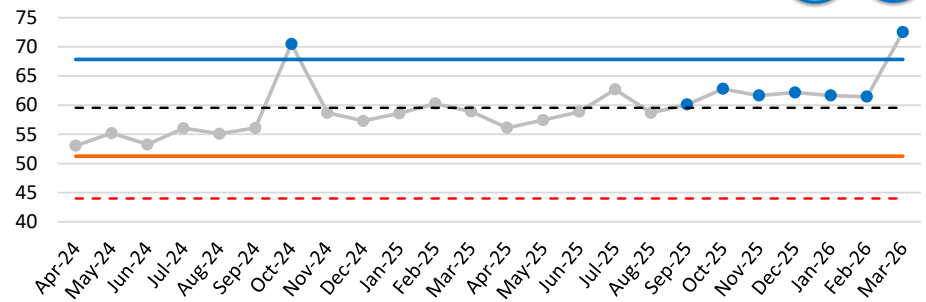
Finance

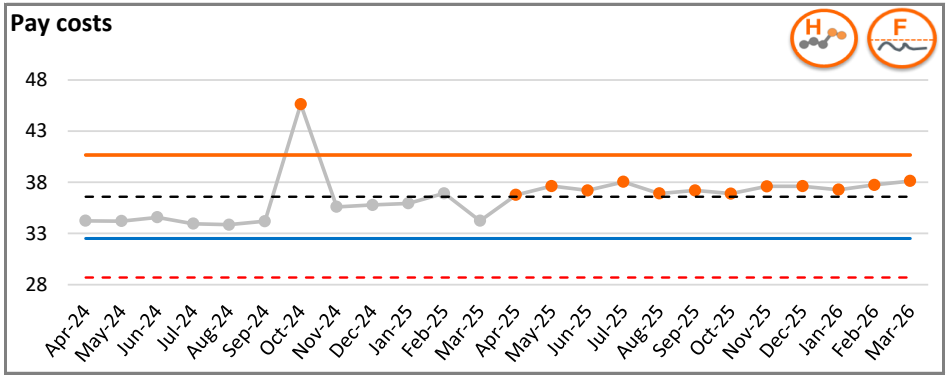
Key Financial Drivers

NHS East and North Hertfordshire Teaching NHS Trust

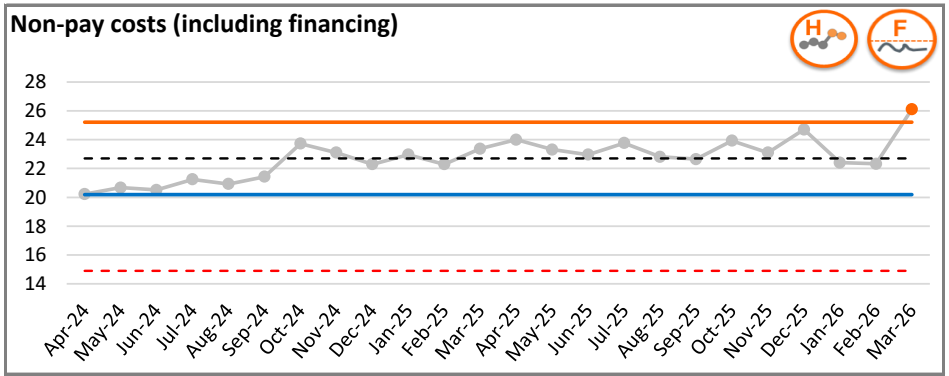
Income earned



Pay costs



Non-pay costs (including financing)



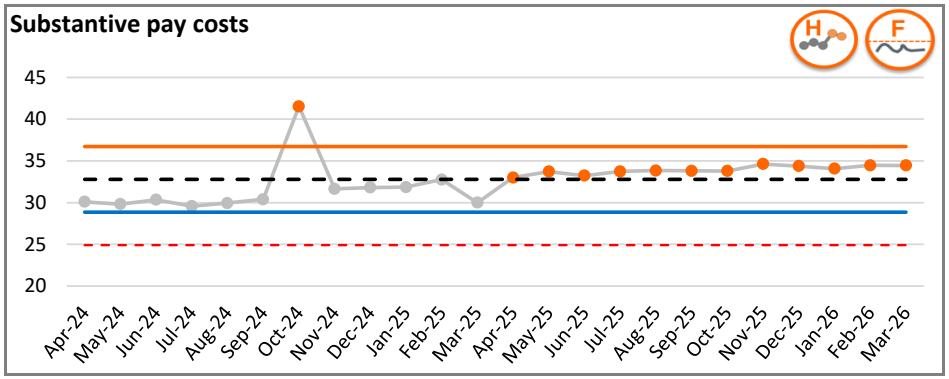
- The Trust has reported a £5m surplus for 2025/26, this is subject to external audit validation.
- The reported position includes £4.9m of additional funding received from NHSE in March relating to the redistribution of deficit support funding (DSF) from other Organisations. This funding was accompanied by an expectation that the Trust would deliver a surplus of an equivalent value.
- Excluding the impact of the additional DSF funding, the Trust has delivered its original break-even plan. However, this is due to the release of significant non recurrent provisions to offset slippage in CIP delivery and BAU pressures.
- The final year end position includes the impact of cover of industrial action and the loss of ERF activity as a result. This has partially been offset by £0.6m of funding to cover the December industrial action only. The net year to date industrial action impact has resulted in a £1.1m adverse variance.
- CIP delivery was £19.3m YTD against a full year target of £35.8m. The adverse variance of £16.5m has resulted in the requirement to release balance sheet flexibilities which are non-recurrent in nature.
- ERF activity YTD is below Divisional phased capacity plans, particularly within the Unplanned Care, Planned Care and Women and Children's Division. However, waiting list payments are £1.8m above the YTD plan, which indicates that not all of the agreed productivity targets have been met.
- There continues to be pay pressures in month particularly within nursing where there is a worrying increase in run rate. Although substantive pay has increased due to recruitment, there has not been a corresponding decrease in temporary staffing. The position has been exacerbated in month by high levels of absence, particularly for sickness which is at 5%.

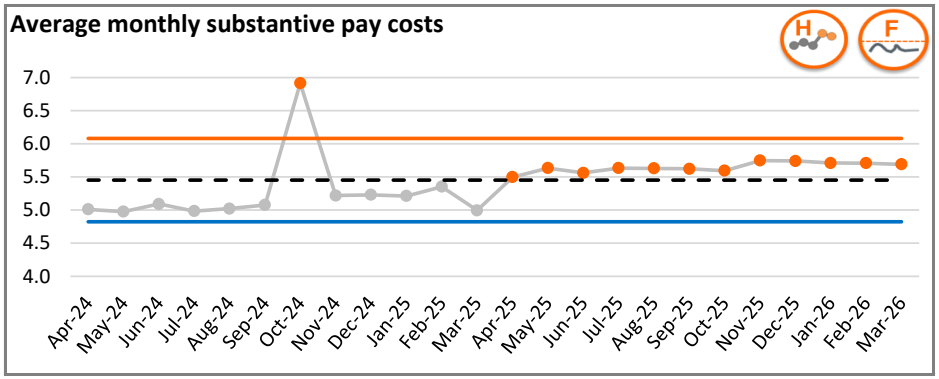
Month 12 | 2025-26

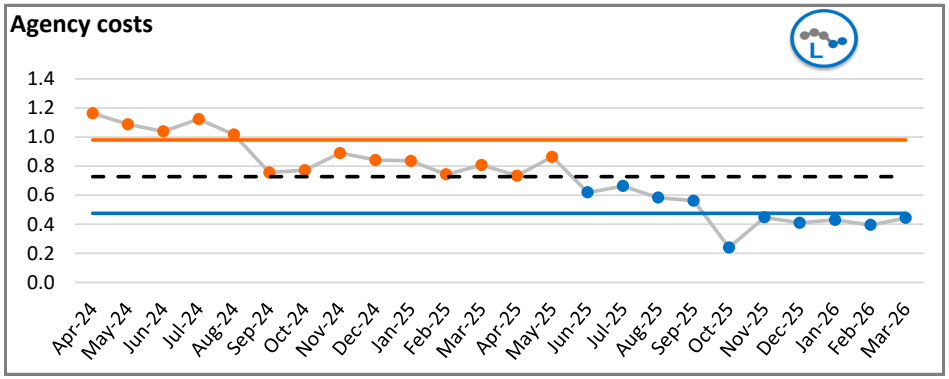
Finance

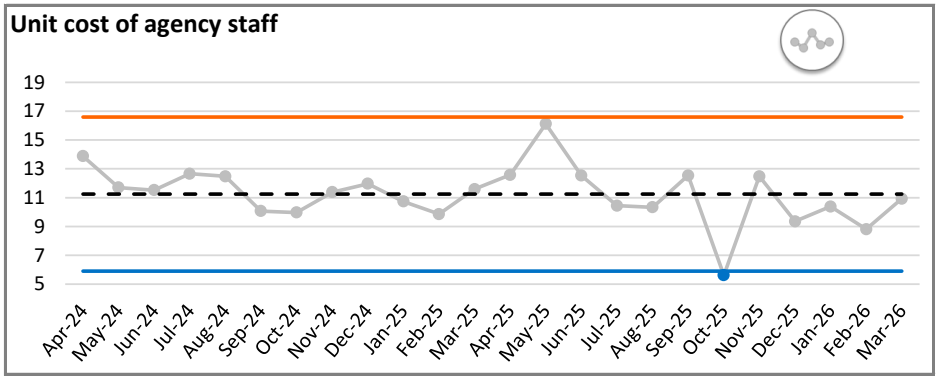
Other Financial Indicators

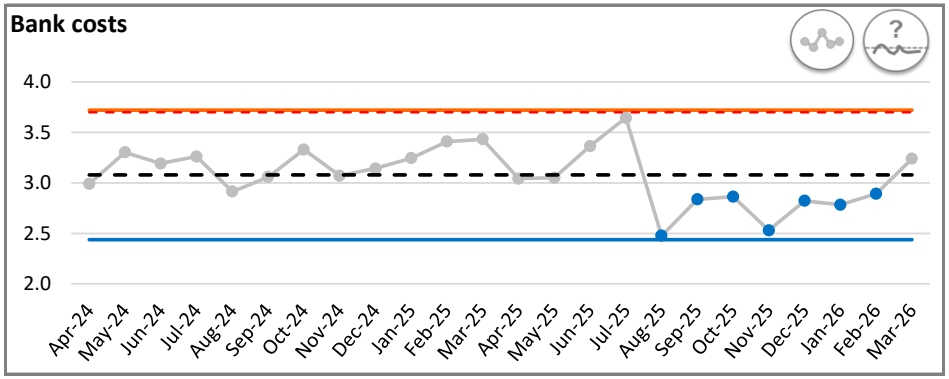
NHS East and North Hertfordshire Teaching NHS Trust

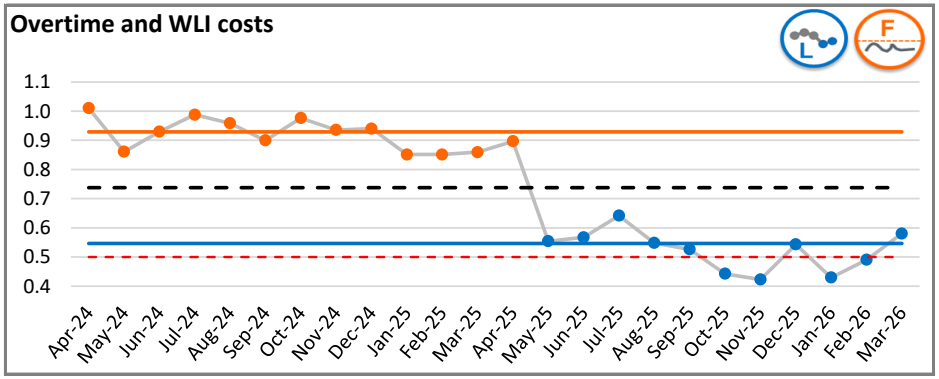












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NHS
East and North Hertfordshire Teaching
NHS Trust

People

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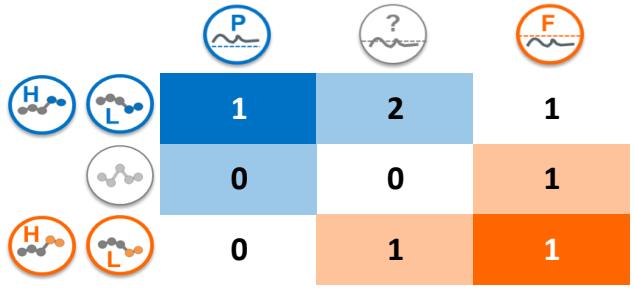

People

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Mar-26	8%	5.6%			6 points below the lower process limit Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Mar-26	5%	8.6%			8 points below the mean Metric will consistently fail the target
	Agency spend as a proportion of WTE	Mar-26	3%	1.1%			6 points below the lower process limit Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Mar-26	90%	88.0%			7 points below the mean Metric will inconsistently pass and fail the target
	Appraisal rate	Mar-26	90%	86.2%			Common cause variation Metric will consistently fail the target
Thrive	Turnover rate	Mar-26	10.5%	7.1%			12 points below the mean Metric will consistently pass the target
Care	Sickness rate	Mar-26	4.0%	5.0%			7 points above the mean Metric will consistently fail the target

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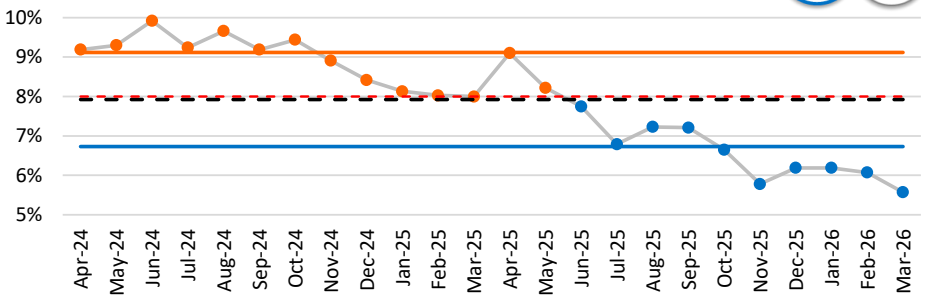
People

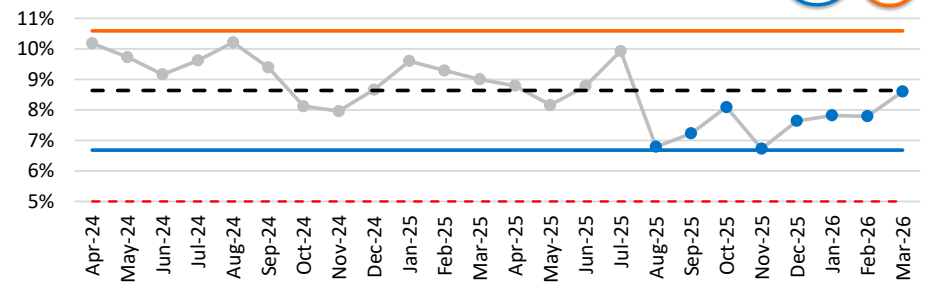
Work Together

East and North Hertfordshire Teaching NHS Trust

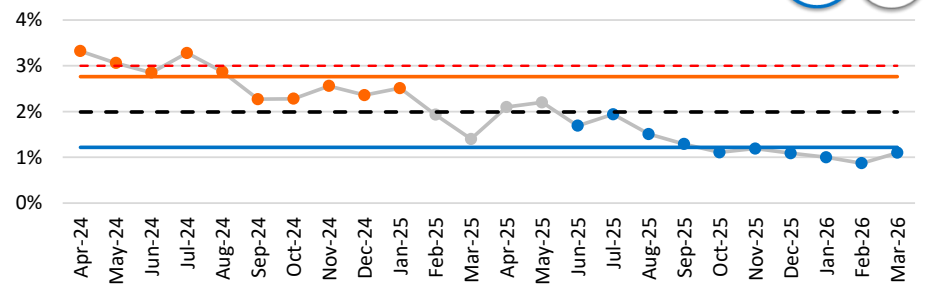
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- Average time to hire increased, partly due to unexpected absence in team and CSWs being held in a talent pool awaiting vacancy approvals. Team working to strengthen processes to improve resilience and confirm outstanding CSW vacancies to proactively targeting areas.
- Recruitment experience increased to 5/5. Candidate feedback has been highly positive reflecting the Resourcing team's continued focus on maintaining positive candidate experience.
- Focus remains on reducing CSW vacancies and reducing bank spend. Line by line review of bank CSW usage continues, comparing vacancy data and pipeline to ensure clear plan to reduce and end bank usage for vacancies.
- Workforce plan and recruitment strategy being developed for Radiology where vacancy rates, turnover, and reliance on bank and agency staff remain high. Initial focus on understanding recruitment pipelines and supporting development of targeted strategy.
- In the last quarter, the relative likelihood of a white applicant being shortlisted and appointed compared to a BAME applicant increased slightly, and as well as likelihood of a non-disabled applicant being shortlisted and appointed compared to a disabled applicant. Figures are based on Trac data and do not fully reflect all new starters for the quarter. Work continues to prioritise inclusion and aims to support fair and transparent recruitment processes. Additionally, team has identified several initiatives to improve the accessibility of the recruitment process for applicants with disabilities.
- Temporary staffing spend is 2% above the 8% target, Agency spend as a proportion of WTE remains below target. Bank is above target. Proactive review continues of usage against vacancies.
- M12 Nursing and CSW spend is a high area of focus, drivers include annual leave at top end of KPI, high levels of 'ward-based' sickness for nurses this year, supernumerary periods, and the pressure of using bank to backfill staff on training placements. Corrective actions include review of controls, and sickness run rates.

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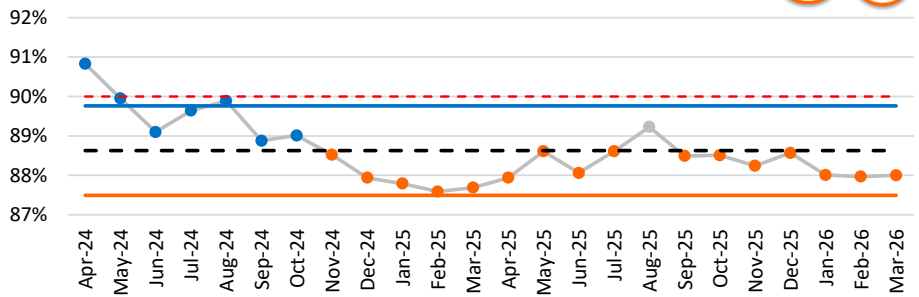
People

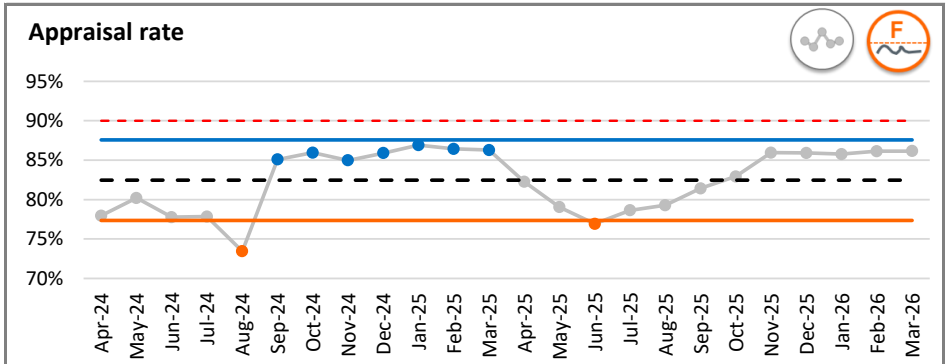
Grow Together

East and North Hertfordshire Teaching NHS Trust

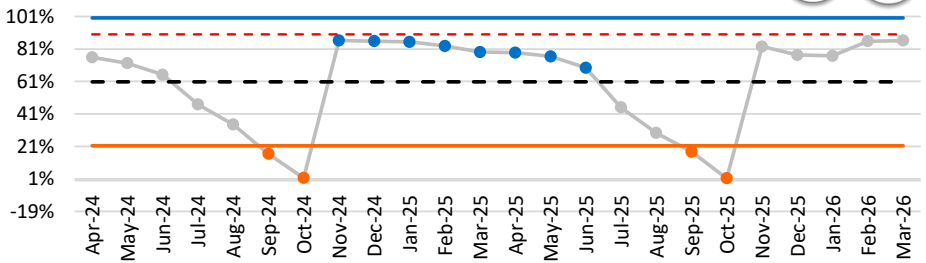
Statutory and mandatory training compliance rate



Appraisal rate



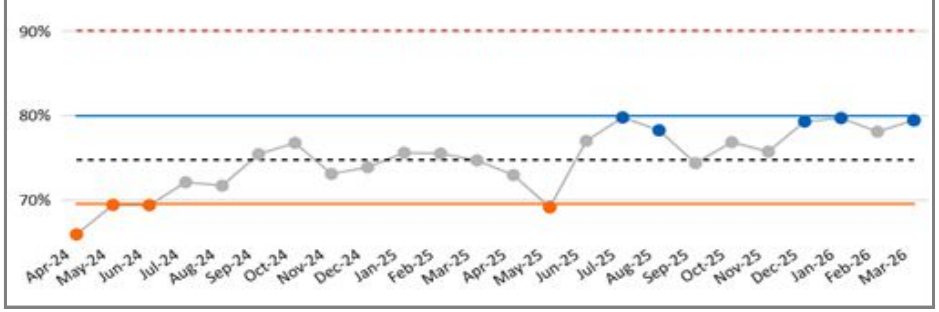
Grow Together (GTR)



Key Issues and Executive Response

- **GTR compliance** for Mar is 85.8%. This means circa 990 of our people have not had a GTR this year. Power BI allows all line managers to review their team compliance data. Compliance figures will now be zeroed from 1st April to align with our goal cascading and working towards shared strategies across the organisation.
- **UCL & UoH Education Risks**: Wi-Fi issues pose immediate risk to UCL student placements; Uni of Hertfordshire September 2026 cohort planning is underway but dependent on confirming funding for the new Clinical Link Tutor role.
- **Regulatory & Operational Pressures**: GMC action plan requires further evidence to avoid escalation; ongoing vacancies are impacting capacity despite recent successful recruitment.
- **Infrastructure & Process Changes**: AV failures at Lister Education Centre require expedited repairs; transition to new study leave/expenses systems in April 2026 will need careful rollout to avoid disruption.
- **Moving & Handling**: Introducing MS Forms for competencies (awaiting approval) and reviewing bariatric equipment processes to reduce delays and overspend.

Medical appraisal compliance



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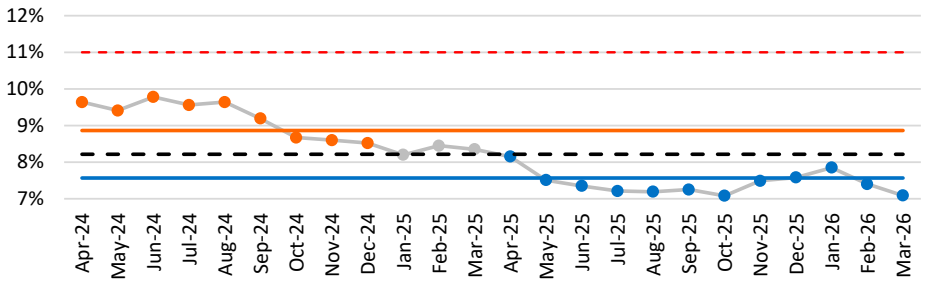
People

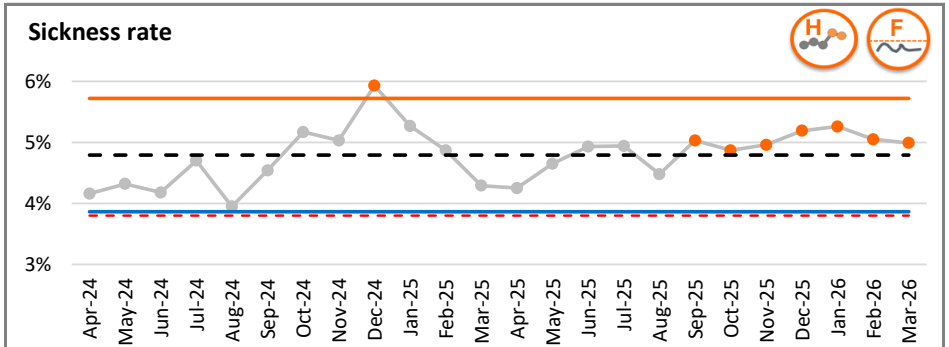
Thrive Together | Care Together

NHS East and North Hertfordshire Teaching NHS Trust

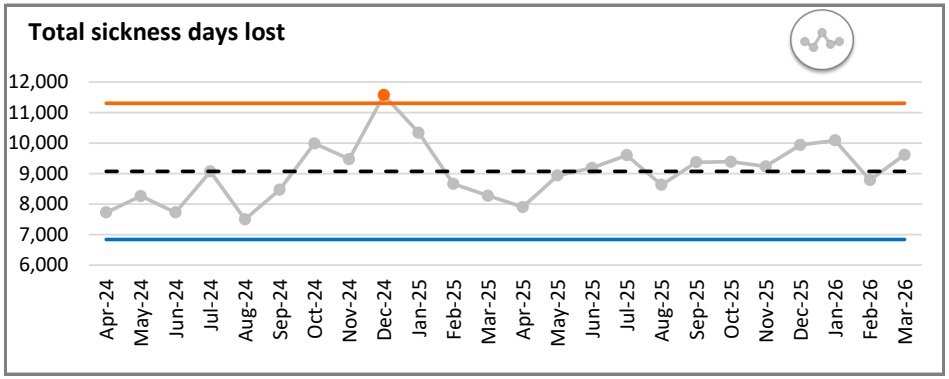
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- Suspension case closed and no other open suspensions.
- Average duration of disciplinary cases remains within KPI and has reduced due to two long standing cases being concluded with one resulting in a formal warning and other resulting in no case to answer.
- Average duration of grievances has increased again this month however 3 long standing cases have been closed and 3 other are due to close this month following legal advice.
- An increase in reporting both sexual misconduct and IG breaches has been shared with people partners to identify interventions with teams as appropriate.
- Sickness absence is on downward trajectory however there are still some Care group/Division hotspots that will need continued intervention. Interventions including sickness review clinics, heavy monitoring of hotspot areas and check and challenge meetings to ensure managers are supporting ongoing sickness absence cases.

Care Together

- Stress and mental health conditions continue to be a leading cause of sickness absence. The new stress policy has been promoted in wellbeing walkabouts to encourage stress risk assessment and implementation of proactive measures to reduce and manage stress.
- The Health at Work service have worked in partnership with the Trust Charity to secure funding from NHS Charities together to support the delivery of a virtual group-based mental wellbeing programme. The project is designed to provide early, accessible support to staff across five local Trusts experiencing stress, anxiety, burnout, or mental health challenges. This initiative will complement existing wellbeing support by providing a proactive, intervention that can help staff improve their mental wellbeing, build resilience, and reduce sickness absence.

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Board committee report

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NHS
East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	14
Report title	Quality and Safety Committee report to the Board;			**Meeting Date**	13 May 2026
Chair	Dr David Buckle, Committee Chair				
Author	Deputy Trust Secretary				
Quorate	**Yes**	☒	**No**		☐

Alert (Matters of concern or key risks to escalate to the Board):

- There was a sharp rise in CQC concerns, with 13 new issues raised in January–February 2026, reflecting operational pressures and increased staff escalation.
- Significant clinical and governance risks were identified in the Orthotics service, including anticipated harm in the paediatric cohort and challenges linked to external providers.
- MRI waits remain a major risk, with delays of up to 159 days and a long-term programme required to resolve data and pathway issues.
- Digital fragmentation across the Trust continues to limit clinical visibility, create data inconsistencies and weaken governance.
- Staff parking pressures are worsening and are impacting staff morale and punctuality.

Assurances provided to the Board:

- The Committee received substantial assurance from the Maternity and Perinatal report, which confirmed continued improvement since exiting the national safety support programme.
- Substantial assurance was also received from the Learning from Deaths Q3 report, with strengthened processes and a transition to a new SJR methods
- Reasonable assurance was given from the Integrated Compliance Report, supported by better triangulation of patient, staff and clinical data.
- Reasonable assurance was provided through the Planned Care deep dive, which showed improved governance and falling incident rates.
- The Committee noted that antibiotics were consistently delivered within 10–15 minutes as part of the sepsis pathway.

Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):

- Obstetrics reported a rise in 3rd/4th degree tears, with a multidisciplinary review under way to understand causes. Maternity continues to face challenges including manual screening processes, workforce fragility, and limited translation tools.
- Length of stay increases appear linked to changes in ED coding rather than clinical deterioration.
- VTE compliance has improved to over 80% due to strengthened ED and planned care processes.

Decisions made by the committee or major actions commissioned and work under way:

- Obstetrics will report back in June 2026 on the increase in obstetric tears.
- The Sepsis team will prepare a dual-reporting proposal balancing clinical granularity with national compliance.
- A written update on the Orthotics PSII and mitigation will be submitted to a future meeting.

• An updated Risk Oversight Policy will be presented in June 2026. • Maternity will present the full external review action plan in May 2026. • Executives will report back in April on short-term staff parking mitigations. • The Medical Director has confirmed since the meeting that the organ transplant concerns raised in a national TV documentary do not apply to this Trust. It was noted that our performance in identifying possible cases was good.
Any actions recommended to improve effectiveness of the meeting:
• Data harmonisation across systems will be prioritised to support clearer and more reliable reporting.

Recommendation	The Board is asked to **DISCUSS** the report to the board

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Board committee report

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board	**Agenda Item**	15
Report title	Finance, Performance and Planning Committee – March 2026	**Meeting Date**	13 May 2026
Chair	Richard Oosterom – Chair and Non-Executive Director		
Author	Committee Secretary		
Quorate	**Yes** ☒	**No** ☐	

Alert (Matters of concern or key risks to escalate to the Board):

February and March:

- Persistent operational fragility across **RTT, UEC and diagnostics**, with ongoing risks to sustainability and deliverability of trajectories.
- **ENT and Oral Surgery capacity constraints** due to CBCT reporting limitations; mitigation via outsourcing implemented but remains a capacity risk.
- **UEC performance remains below trajectory**, with overnight waits, corridor care risk, and delayed transfers of care continuing to present quality and flow challenges despite early signs of improvement.
- **Financial position held to plan only through significant non-recurrent support**, with a materially deteriorating underlying run-rate and continued reliance on ERF flexibilities.
- **Theatres and elective productivity** continue to underperform, with sterile services disruption and cancellations repeatedly highlighted as a system bottleneck.
- PTL data quality identified as a **material patient safety risk** following external GIRFT review, requiring a sustained, trust-wide improvement programme.

Assurances provided to the Board:

February and March:

- **Cancer performance** met all national standards during the reporting period, with January performance ranking **7th of 119 Trusts nationally** for 62-day performance; committee commended the Cancer team and requested sharing of best practice.
- RTT performance showed **gradual improvement**, remaining above national minimum trajectory in March, though margins remain tight and vulnerable to disruption.
- Diagnostics performance showed **early recovery signals** (DM01 improvement; seven-day MRI rota implemented from April).
- Financial controls and governance are being strengthened through enhanced scrutiny frameworks, WLI panels and refreshed control processes.

Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):

February and March:

- **26/27 planning and contracting** substantially advanced, with agreement reached on a **£491.8m contract value** with Central East ICB and submission accepted by the Committee.
- Specialist commissioning positions progressed positively; earlier income gaps have been significantly reduced, though some specialties lack credible recovery without workforce investment.
- The **Transformation Programme has been reset**, with a stronger focus on delivery discipline, weekly finance engagement, governance rigour and scheme validation prior to inclusion in plans.
- External consultancy support is being used on a **contingent-fee, delivery-led basis** with clear stop criteria, under Trust-level governance.
- Enhanced Accountability Framework now in cycle five; improvements in tone noted, but **impact not yet sufficiently visible across all divisions**.

Decisions made by the committee or major actions commissioned and work under way:

February:

- Committee reinforced requirement for credible, deliverable plans, rejecting optimistic assumptions not supported by capacity or workforce evidence.

March:

- Committee **approved submission of the revised 26/27 planning position** to the system.
- Committee **approved a voluntary redundancy scheme** for Health Records (24 VRs; £517k cost with one-year payback).
- Established requirement for:
  - PTL (Data Quality) Management
  - Trust-wide Access Plan Framework
  - Specialty-level recovery plans by June 2026
- Requested formalisation of accountability and consequence mechanisms within both the Enhanced Accountability Framework and financial control processes.

Any actions recommended to improve effectiveness of the meeting:

- Strengthen **risk articulation and interpretation** within FPPC papers, particularly in UEC, performance volatility and ex-ward data.
- Improve **workforce representation and translation of decisions into operational action**, ensuring faster delivery against agreed actions.
- Maintain the improved quality of challenge and cross-functional discussion observed during recent meetings

Recommendation	The Board is asked to **DISCUSS** the report from the Committee.

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Board committee report

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	16
Report title	People and Culture Committee 21 April 2026		**Meeting Date**	13 May 2026
Chair	Janet Scotcher – Committee Chair			
Author	Committee Secretary			
Quorate	**Yes**	☒	**No**	☐

Alert (Matters of concern or key risks to escalate to the Board):

- Risk that workforce planning is based on historic service models rather than future demand and system need.
- Committee challenge that organisational change is being treated as episodic rather than continuous, increasing risk of burnout and fatigue if not better managed. This is an area the committee will continue to seek assurance on.

Assurances provided to the Board:

- Assurance that phase two workforce planning work is nearing completion, with improved triangulation of workforce, service demand and financial data, and a detailed case study to be brought to Committee.
- Committee support for extending the Equality, Diversity and Inclusion Strategy, with assurance that the revised EDI Workbook provides a clearer and more focused delivery framework aligned to current context.
- Assurance that the Equality Delivery System (EDS) report is complete, has system agreement, and is ready for publication on the Trust website following minor clarification.
- Positive assurance that the People Dashboard and heatmap provide improved insight into workforce risks and hotspots, with further detailed review planned.

Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):

- Changing workforce expectations post-COVID, including increased demand for agile and flexible working, with growing tension between workforce expectations and organisational need.
- Non-Executive Director observations that there is no expectation of additional national funding, reinforcing the need for realistic local planning, partnership working, and transparent decision-making on service sustainability.
- Deep dive into progression challenges for BAME colleagues identified as selection-based rather than attraction-based, with a need to improve consistency, fairness and assurance at decision points in recruitment processes.

- Workforce and transformation discussions emphasised the importance of supportive infrastructure, systems and tools as enablers of productivity, not just staffing numbers.
Decisions made by the committee or major actions commissioned and work under way:
- Agreement to extend the Equality, Diversity and Inclusion Strategy, with delivery and oversight managed through the revised EDI Workbook. - Agreement that staff survey free-text findings and the proposed focus on three organisational themes will be further developed and presented to the Trust Board. - Approval of the Whistleblowing Policy subject to agreed amendments, including clearer signposting between whistleblowing, Freedom to Speak Up and counter-fraud routes, with onward submission to the Board. - Request for a more in-depth discussion on the People Dashboard and workforce metrics at a future Committee meeting.
Any actions recommended to improve effectiveness of the meeting:
- Committee members recommended greater use of in-depth case studies and practical examples, particularly for workforce planning, productivity and transformation updates, to support deeper understanding and challenge.

Recommendation	The Board is asked to **DISCUSS** the report from the Committee.

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Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	17.1	
Report title	ENH HCP Committee Terms of Reference revisions		**Meeting Date**	13 May 2026	
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:

Revised ENH HCP Committee Terms of Reference (known by partners as the ENH HCP Board) are presented as tracked changes for approval. The proposed changes have been endorsed at the 1 May HCP Committee meeting, following robust consideration and development at two previous HCP Committee sessions.

Two changes are proposed:

- Revised membership:
  - ICB representative numbers have reduced reflecting the old ICB's committee (that up to 31 March 2026 was meeting in common with the ENHT HCP Committee) has ceased and the meeting is now solely a committee of ENHT in the context the ICB having a reduced workforce and wider footprint. However, an ICB representative is still retained.
  - Partner organisations members who have been attending are named and set out explicitly.
  - Clarifying primary care representation with ENHGP representation added.
  - Adding Public Health and Children and Young People Council representation.
- Voting rights – simple majority voting was reaffirmed/supported but adding the Chair has the casting vote, in the event of a tied vote, to address a deadlock risk.

No other changes are proposed in the context we are awaiting confirmation on whether the ICB wishes to proceed with delegated decision-making from the ICB to HCPs. If this happens, the delegation agreement will be brought to the Board as well as revised Terms of Reference.

Please note that the HCP on 1 May confirmed there is currently no intention to create sub-committees with the intention of keeping the focus on delivery, with supporting management meetings. Therefore, whilst the Terms of Reference allow for an appendix 1 with sub-committees, no sub-committees exist or are currently planned.

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 Board membership is intended to be small enough to allow efficient decision-making and for meetings to stay to a reasonable length (the more people in the meeting the longer

meetings can run) whilst still enabling a broad spectrum of key partners to help make decision-making robust for the benefits of patients/service users.							
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):							
1 May HCP Committee endorsement of the revised Terms of Reference following two development sessions on 17 November 2025 and 6 February 2026.							
Recommendation	The Board is asked to **APPROVE** the revised Terms of Reference for the ENH HCP Committee.						

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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 Board

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 whilst in shadow form, with the intention of the ENHT 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 convener 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. 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: • Chair - HCP Senior Responsible Officer (ENHT CEO) (or ENHT deputy) • Vice-Chair - HCT Executive representative • East and North Hertfordshire HCP Development Director (or deputy) • Healthwatch representative • Hertfordshire County Council, Adult social care • Hertfordshire County Council, Children & Young People • Hertfordshire County Council, Public Health • HPFT Executive representative • HUC/111 representative (added but agreed starts attending or removed) • ICB chosen representative e.g. Hertfordshire Place Director (or deputy) • Non-executive member of ENHT Board • Non-executive member of HCT Board • Representative from GP Federation • Primary care representative • VCFSE Alliance representative ~~• HCP Senior Responsible Officer(s) (Elliot Howard-Jones and Adam Sewell-Jones)~~ ~~• 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 and 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. In the case of a vote, simple majority rules apply (over 50% of voting members present), with the Chair having a casting vote in the event of a tied 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 ENHT 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
V2	17 March 2026	To HCP Board		Membership & voting rights

Board committee report

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NHS
East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	18
Report title	Audit and Risk Committee report to the Board meeting held 31/3 2026			**Meeting Date**	13 May 2026
Chair	Mrs Karen McConnell, Committee Chair				
Author	Deputy Trust Secretary				
Quorate	**Yes**	☒	**No**		☐

Alert (Matters of concern or key risks to escalate to the Board):

- Internal audit work identified several areas with partial assurance, including PSIRF, payroll processes and key health and safety domains, indicating that important control improvements are still required.
- The Medical Appraisals review received minimal assurance, although improvements are progressing, including backlog clearance, strengthened data integrity and enhanced quality assurance processes. The Committee noted that just two actions remained outstanding and that these were being actively addressed.
- The draft Head of Internal Audit Opinion for 2025/26 is Amber/Red, reflecting the number of critical findings and governance weaknesses.

Assurances provided to the Board:

- Internal audit reported reasonable assurance on key financial controls, demonstrating overall strength in these areas.
- External Audit identified two new VFM risks of significant weakness in respect of Medical appraisals (Governance) and ENHPharma stock findings (Governance). Aside from these no new audit risks or misstatements have been identified. Some persistent issues in relation to IT systems were noted and will be followed up by the Committee.
- The Committee received positive assurance on progress against internal audit actions, with 48 actions closed since the previous meeting.
- The Committee received an update on the pilot of the Cancer Division's self-assessment against the Good Governance Maturity matrix. The Division showed clear and measurable progression in 7 of the 8 domains with the pilot model adding measurable value. Expressions of interest are being sought to extend the pilot.

Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):

- The Committee approved the 2026/27 Internal Audit Plan and the LCFS work plan.
- The MEA valuation work remains on track, with phases one and two completed and auditors confirming they have the documentation required.
- Freedom of Information performance has been escalated corporately, and divisional leads are in place to improve response rates.
- The Scheme of Reservation and Delegation has been updated, including strengthened approval limits and a commitment to develop an AI-supported navigation tool.
- A cyber assurance self-assessment was reported to ARC using the National Audit Office Cyber security and resilience good practice guide. This links to the DSPT assessment. The self-assessment will be considered by TMG before returning to the Committee in July.
- LCFS activity and training continue to progress, with the work plan for 2026/27 approved.

Decisions made by the committee or major actions commissioned and work under way:	
• The Committee approved the Internal Audit Plan and Strategy and requested full versions of all minimal and partial assurance reports in future packs. • Oversight of Medical Appraisal improvements will transfer to the People & Culture Committee, with ARC retaining oversight of remaining actions. • Oversight of PSIRF improvements will transfer to the Quality and Safety Committee and its Patient Safety Sub-committee, with ARC retaining oversight of the remaining actions. • External audit issues relating to journal descriptions and IT control will be updated at the next meeting. • Local Counter Fraud raised a high-priority case involving unverified sponsorship documentation. An update will be provided to ARC at its next meeting • A litigation report will be added to the annual cycle and brought to ARC each year. • The cyber security action plan will be reviewed at TMG and return to ARC in July. • LCFS recommendations will be integrated into the internal audit action tracker from 2026/27.	
Any actions recommended to improve effectiveness of the meeting:	
• The Committee emphasised the need for timely and robust evidence submission to audit teams. • Members stressed the importance of ensuring clear ownership of cyber security responsibilities across the organisation. • The Committee recommended realistic implementation deadlines for internal audit actions, with escalation where required.	
Recommendation	The Board is asked to **DISSCUSS** the report to the Board.

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Board committee report

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NHS
East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	18a
Report title	Audit and Risk Committee report to the Board meeting held 14/4/2026			**Meeting Date**	13 May 2026
Chair	Mrs Karen McConnell, Committee Chair				
Author	Deputy Trust Secretary				
Quorate	**Yes**	☒	**No**		☐

Alert (Matters of concern or key risks to escalate to the Board):

- Risks and dependencies associated with the upgrade to OneEPR were highlighted, with concern about reliance on future delivery rather than current mitigations; RMG is reviewing and this may need a Board-level discussion.

Assurances provided to the Board:

- The Internal Audit Risk Management Review which included the Board Assurance Framework review received a reasonable assurance rating.
- Fire safety remains one of the Trust's highest estate risks however, fire safety governance and controls have strengthened, including revised policies, an emerging Trust-wide strategy and improved risk assessments.
- A report from KPMG on the control environment of ENHPharma was received. Progress is being made on the implementation of recommendations and a further report back to ARC is scheduled for July.
- ARC approved the Audit plan from the external auditors, Moore Kingston Smith, for ENH NHS Charitable Fund.

Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):

- Cross-cutting risk themes continue around workforce sustainability, waiting lists, digital maturity and estates infrastructure.
- Quality Account requirements are evolving under the new ICB governance arrangements. ARC requested an update on requirements and progress prior to their submission to Quality and Safety Committee in June.
- Fieldwork is underway for the first of the internal audit 26/27 reviews, Freedom to Speak Up.

Decisions made by the committee or major actions commissioned and work under way:

- The Corporate Risk Register cyber security entry will be updated to include appropriate high-level mitigations and assurance.
- Upgrade to OneEPR-related risks to be considered by RMG and escalated for board discussion.
- Assurance mapping within the Board Assurance Framework will progress with mapping complete by December 2026.
- A Quality account requirement checklist will be provided to committee members ahead of submission.

Any actions recommended to improve effectiveness of the meeting:

- Improved focus on interpreting assurance information rather than producing/receiving it

• Continued rationalisation and challenge of the Corporate Risk Register to maintain board-level effectiveness.	
Recommendation	The Board is asked to **DISCUSS** the report to the Board.

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Board committee report

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	19
Report title	Digital Committee Report to the Board For 7 April 2026			**Meeting Date**	13 May 2026
Chair	Richard Oosterom				
Author	Governance Business Administrator				
Quorate	**Yes**	☒	**No**		☐

Alert (Matters of concern or key risks to escalate to the Board):

OneEPR delivery failure and loss of assurance

- Only approximately 50% of the agreed OneEPR Minimum Viable Product (MVP) delivered by 27 March 2026.
- Delay is not isolated; there has been an ongoing pattern of missed deadlines from Dedalus.
- MVP does not yet adequately address integration, increasing technical and clinical risk.
- Delivery now forecast to the end of June 2026, making the planned November 2026 go-live unachievable and requiring a revised 2027 go-live.
- Digital Committee concluded the programme currently provides **minimal assurance.**

Assurances provided to the Board:

Active senior oversight and challenge

- The Digital Committee robustly challenged Dedalus performance, causes of delay, and clinical impacts, with Non-Executive Directors explicitly raising patient safety and operational concerns.

Formal strengthening of delivery controls

- Agreement to establish a formal, version-controlled specification baseline with defined sign-off and change control for dashboards, forms, and future deliverables, to address ambiguity and reduce scope drift.

Clear near-term delivery commitments

- Dedalus confirmed commitment to completing the MVP by **30 June 2026**, with the Trust explicitly stating that delivery timelines cannot be further compressed due to safety and readiness constraints.

Improved transparency and progress monitoring

- Dedalus committed to:
  - Providing a detailed delivery schedule for all outstanding phases of the programme (MVP, Core and full EPR) by **30 April 2026.**
  - Delivering weekly progress updates and show-and-tell sessions to provide increased visibility and early identification of issues.

Enhanced on-site supplier presence

- Dedalus agreed to provide an ongoing schedule of on-site attendance, responding to concerns about insufficient face-to-face engagement and delivery effectiveness.

Pragmatic, risk-managed implementation approach

- The Committee supported a conditional “middle-ground” approach: proceeding with the MVP only if the Trust gains sufficient confidence in the remainder of the product prior to any Trust-wide go-live, avoiding a partial or unsafe implementation.

Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):

Intensified national scrutiny of EPR implementations

- National oversight and assurance processes for EPR go-lives have increased, meaning any revised OneEPR go-live date will require external approval and

heightened scrutiny, with potential implications for timetable and assurance requirements.

Dependency on future clarity to resolve outstanding risks

- Some actions and risk reviews remain paused pending clarity on the programme's long-term direction, meaning parts of the risk profile cannot yet be fully closed or mitigated.

Continued strain on organisational capacity

- The scale and intensity of the OneEPR recovery effort is consuming significant senior clinical, operational, and digital leadership capacity, which the Board should note when considering broader delivery expectations.

Expectation of further escalation if confidence does not improve

- The Committee signalled that, should delivery milestones not be met or confidence further erode, additional escalation and potentially more radical options may need to be brought to the Board for decision.

Decisions made by the committee or major actions commissioned and work under way:

- Decision to explore commercial remedies if required, whilst maintaining the priority of timely and safe delivery.
- **Decision to escalate supplier performance concerns at executive level**:
  - Agreement to hold a **CEO-to-CEO meeting** between the Trust and Dedalus to address delivery failures, impact, and potential remedies.
- **Decision to require a credible high-level plan for the core product and full EPR**, with milestones sufficient to support mobilisation planning.

Any actions recommended to improve effectiveness of the meeting:

N/A

Recommendation	The Board is asked to **DISCUSS** the report from the Committee.

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Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	20	
Report title	Remuneration & Appointments Committee Terms of Reference revisions		**Meeting Date**	13 May 2026	
Author	Head of Corporate Governance				
Responsible Director	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:

Revised Terms of Reference for the Remuneration and Appointments Committee are enclosed for approval reflecting committee feedback covering one change:

- *"6 m) To receive and review the Chief Executive's objectives."* has been added to the committees duties.

No other changes are proposed in the context changes were made in May 2025 as part of the annual committee effectiveness review relating to 1) adding diversity pipeline oversight 2) removing the requirement for ENH Pharma director remuneration to come to Remuneration Committee (unless the remuneration percentage change is proposed to be higher than other ENH Pharma staff).

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**	☐

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):

Members of the Remuneration and Appointments Committee reviewed and supported the change at its meeting on 24 March 2026.

Recommendation	The Board is asked to **APPROVE** the revised Terms of Reference for the Remuneration and Appointments Committee.

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East and North Hertfordshire Teaching NHS Trust

REMUNERATION AND APPOINTMENTS COMMITTEE (EXECUTIVE)

TERMS OF REFERENCE

1. Purpose

To approve, on behalf of the Board, the appropriate 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. To monitor the level and structure of remuneration for senior management below Executive Directors.

2. Status and Authority

The Committee is constituted as a standing committee of the Trust Board and derives its powers from the Board of Directors (the Board) and has no executive powers, other than those specifically delegated in these terms of reference. The Committee is authorised:

a) To seek any information it requires from any employee of the trust in order to perform its duties;
b) To obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference; and
c) To call any employee to be questioned at a meeting of the Committee as and when required.

The Committee shall adhere to all relevant laws, regulations and policies in all respects including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate executive directors and senior staff whilst remaining cost effective.

3. Membership

The Committee shall be made up of the Chair of the Trust and three additional non executive directors.

Only members of the Committee have the right to attend Committee meetings.

Other individuals such as the Chief Executive, Chief People Officer, Trust Secretary, the Chair or Managing Director of the subsidiary and external advisers may be invited to attend for all or part of any meeting, as appropriate.

The Chair of the Board of Directors shall chair the meeting.

In the absence of the Committee chair and / or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting who would qualify under these Terms of Reference to be appointed to that position by the Board.

4. Quorum

The quorum necessary for the transaction of business shall be 3 non executive directors. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

5. Frequency of Meetings

The Committee shall meet at least twice a year and otherwise as required. Ordinarily the Committee will plan to meet four times throughout the year, however if remuneration decisions are required for new appointments or there are other urgent matters for the Committee to consider then additional meetings may be held.

In exceptional circumstances when an urgent decision is required and it is not possible to schedule an additional meeting of the Committee, with the agreement of the Chair, decisions may be made by virtual correspondence.

Notice of meetings
Meetings of the Committee shall be summoned by the secretary of the Committee at the request of the Committee Chair or any of its members. Meetings for the year should be scheduled at the start of the financial year.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees, as appropriate, at the same time.

Minutes of meetings
The secretary shall minute the proceeding and resolutions of all Committee meetings, including the names of those present and in attendance.

6. Duties

The Committee shall:

a) Determine and agree the framework or broad policy for remuneration and terms of service of the Trust's Executive Directors and other staff that are not covered by Agenda for Change or Medical and Dental Terms and Conditions;
b) In determining such policy, take into account all factors which it deems necessary. The objective of such policy shall be to ensure that Executive Directors of the Trust are provided with appropriate incentives to encourage enhanced performance and are, in a fair and responsible manner, rewarded for their individual contributions to the long term success of the trust;
c) Design remuneration policies and practices to support strategy and promote long term sustainable success, with executive remuneration aligned to the Trust's purpose and values, clearly linked to the successful delivery of the Trust's strategy;
d) Review the ongoing appropriateness and relevance of the remuneration policy, taking into account its relationship and relativity with remuneration policies and terms and conditions in place for other staff groups;
e) Ensure that any contractual terms on termination (termination of Executive Directors is reserved to the Board), and any payments made, are fair to the individual and the

Trust, aligned with the interest of the patients, that failure is not rewarded and that the duty to mitigate loss is fully recognised;

f) Within the terms of the agreed policy and instructions issued by NHS England/Improvement (NHSE/I), and in consultation with the chair and/or chief executive, as appropriate, determine the total individual remuneration package of each Executive Director including but not limited to bonuses, incentives and other payments such as relocation expenses;
g) Oversee succession planning within the Trust and review the succession planning and talent map annually
h) Oversee the development of a diverse pipeline of officers into senior grades;
i) Receive assurance regarding the selection criteria, selecting, appointing and setting the terms of reference for any remuneration consultants who advise the Committee, and to obtain reliable, up-to-date information about remuneration in other Trusts.
j) Receive assurance regarding the process for the appointment / removal of the Chief Executive and Executive Directors.
k) Receive assurance regarding the Appointment Panel process for Executive appointments. Assurance may be provided after the Appointment Panel process.
l) To monitor the level and structure of remuneration for senior management below Executive Directors.
~~l)~~m) To receive and review the Chief Executive's objectives.

Regarding a subsidiary:

~~m)~~n) Approve Director appointments and remuneration on appointment to the subsidiary Board;
~~n)~~o) Approve remuneration that exceeds agenda for change inflationary increases for subsidiary Company Directors relating to subsidiary work. For the avoidance of doubt, inflationary increases in line with Agenda for Change and staff bonuses in line with subsidiary staff bonuses are not reserved to the Trust Remuneration and may be determined by the subsidiary's Remuneration Committee.

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Other matters

The Committee shall:

a) Have access to sufficient resources in order to carry out its duties, including access to the trust secretariat for advice and assistance as required;
b) Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
c) Give due consideration to all relevant laws and regulations, NHSE guidance and the provisions of the Code of Governance;
d) Ensure that no director or senior manager shall be involved in any decisions as to their own remuneration outcome,
e) Work and liaise as necessary with other board committees, ensuring the interaction between committees and with the board is reviewed regularly.

7. Reporting arrangements

The Committee chair shall report formally to the Board, following each Committee meeting held and at least bi-annually, on its proceedings on all matters within its duties and responsibilities.

The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

An annual statement of the Trust's remuneration policy and practices which will form part of the Trust's Annual Report and register of attendance.

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

The committee shall:

a) Ensure that a periodic evaluation of the committee's own performance is carried out.
b) At least annually, review its terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

9. Support

The Trust Secretary or their nominee shall act as secretary of the Committee.

East and North Hertfordshire Teaching NHS Trust

Board Annual Cycle 2026-27

Notes regarding the annual cycle:

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

Items	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027
Standing Items													
Chief Executive's Report	X		X		X		X		X		X		X
Integrated Performance Report	X		X		X		X		X		X		X
Board Assurance Framework	X				X		X		X		X		X
Corporate Risk Register (Part 2)	X				X				X				X
Patient/Staff Story (Part 1 where possible)	X		X		X		X		X		X		X
Employee relations (Part 2)	X		X		X		X		X		X		X
Board Committee Summary Reports													
Audit Committee Report	X		X		X		X		X		X		X
Charity Trustee Committee Report	X				X		X		X		X		X
Finance, Performance and Planning Committee Report	X		X		X		X		X		X		X
Quality and Safety Committee Report	X		X		X		X		X		X		X
People Committee	X		X		X		X		X		X		X
Digital Committee	X		X		X		X		X		X		X
Digital Committee ToR											X		

East and North Hertfordshire Teaching NHS Trust

Board Annual Cycle 2026-27

Items	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027
Strategic reports													
Planning guidance											X		
Winter Planning (annual)							X						
Digital update			X										
Trust Strategy refresh and annual objectives	X												X
Antimicrobial resistance	X												X
Strategy delivery report					X						X		
Strategic transformation & digital update			X						X				
Integrated Business Plan									X				
Annual budget/financial plan													
System Working & Provider Collaboration (ICS and HCP) Updates	X		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update (Part 2)	X		X		X		X		X		X		X
Estates and Green Plan													
Workforce Race Equality Standard							X						
Workforce Disability Equality Standard							X						
Whistle blowing	X												X
NHS England capability self-assessment					X								
Enabling Strategies													
Estates and Facilities Strategy									X		X		

East and North Hertfordshire Teaching NHS Trust

Board Annual Cycle 2026-27

Items	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027
People Strategy			X								X		
Green Strategy					X								
Quality& Clinical Strategy									X				
Equality, Diversity and Inclusion Strategy	X												X
Digital Strategy			X										
Engagement Strategy							X						
Other Items													
Audit Committee													
Review of Trust Standing Orders and Standing Financial Instructions (if required)			X										
Charity Trustee Committee													
Charity Annual Accounts and Report									X				
Charity Trust TOR and Annual Committee Review											X		
Finance, Performance and Planning Committee													
FPPC TOR and Annual Report											X		
Quality and Safety Committee													
Maternity Incentive Scheme for sign-off													
Complaints, PALS and Patient Experience Annual Report									X				

East and North Hertfordshire Teaching NHS Trust

Board Annual Cycle 2026-27

Items	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027
Safeguarding and L.D. Annual Report (Adult and Children)									X				
Staff Survey Results			X										
Learning from Deaths			X		X				X		X		
Nursing Establishment Review									X				
Patient Safety and Incident Report (Part 2)			X						X				
Teaching Status Report													
QSC TOR and Annual Review (if required)									X				
Quality account (delegate sign off to QSC at their June meeting)			X										
People Committee & Culture													
Workforce Plan													
Trust Values refresh			X										
Freedom to Speak Up Annual Report					X								
Equality and Diversity Annual Report and WRES							X						
Gender Pay Gap Report			X										
Healthwatch Hertfordshire annual report/presentation on key findings and recommendations							X						

East and North Hertfordshire Teaching NHS Trust

Board Annual Cycle 2026-27

Items	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027
Shareholder / Formal Contracts													
ENH Pharma (Part 2) shareholder report to Board					X								