East and North Hertfordshire NHS Trust

Trust Board Part I

Trust Board Part I

Oak & Beech, LEC, Lister

28 September 2016 14:00 - 28 September 2016 15:15

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	
2	Declaration of Interests		
3	Questions from the Public Members of the public are reminded that Trust Board meetings are meetings held in public, not public meetings. However, the Board provides members of the public at the start of each meeting the opportunity to ask questions and/or make statements that relate to the work of the Trust.Members of the public are urged to give notice of their questions at least 48 hours before the beginning of the meeting in order that a full answer can be provided; if notice is not given, an answer will be provided whenever possible but the relevant information may not be available at the meeting. If such information is not so available, the Trust will provide a written answer to the question as soon as is practicable after the meeting. The Secretary can be contacted by email (jude.archer@nhs.net), by telephone (01438 285454), by fax (01438 781281) or by post to: Company Secretary, Lister Hospital, Coreys Mill Lane, Stevenage, Herts, SG1 4AB.Each person will be allowed to address the meeting for no more than three minutes and will be allowed to ask only one question or make one statement. However, at the discretion of the Chair of the meeting, and if time permits, a second or subsequent question may be allowed.Generally, questions and/or statements from members of the public will not be allowed during the course of the meeting. Exceptionally, however, where an issue is of particular interest to the community, the Chairman may allow members of the public to ask questions or make comments immediately before the Board begins its deliberations on that issue, provided the Chairman's consent thereto is obtained before the meeting.		
4	Apologies for Absence:		
5	Minutes of Previous Meeting To approve the minutes of the meeting held in July 2016 05 Draft mins Pt 1.pdf 7	Chair	
6	Matters Arising and Actions Log For information 06 Pt I Draft Actions Log for September 2016.pdf 15	Chair	
7	Annual Cycle For information 07 Board Annual Cycle 2016-17 revised new format.pdf 17	Company Secretary	

#	Description	Owner	Time
8	Chief Executive's Report For discussion 08 Chief Executive's Report.pdf 21	Chief Executive	
9	Strategic Issues		14:10
9.1	Mortality Report For discussion 09.1 Mortality Report Sep-16.pdf 35	Medical Director	
10	Finance and Performance		14.20
10.1	Finance and Performance Committee report For discussion 10.1 FPC Report_to_Board_Sept 2016-JA.pdf 57	Chair of FPC	
10.1.1	Finance report For discussion 10.1.1 Board_Finance Month 5 final post FPC.pdf 61	Director of Finance	
10.1.2	Performance Report For discussion 10.1.2 September Performance report for FPC_final.pdf 77	Chief Operating Officer	
10.1.3	Workforce Report For discussion. 10.1.3 Workforce Report.pdf 85	Director of Workforce and OD	
11	Risk and Quality		14:40
11.1	Risk and Quality Committee report For discussion 11.1 RAQC Report to Board September Final.pdf 95	Chair of RAQC	
12	Audit Committee Report For discussion 12 AC report to board.pdf 99	Chair of Audit Committee	

#	Description	Owner	Time
12.1	**Annual Auditors Letter** For Information 12.1 Annual Auditors Letter.pdf 103	Audit Committee Chair	
12.2	**Standing Financial Instructions / Orders** For approval .2 Standing Financial Instructions-Orders final .pdf 9	Company Secretary	
13	**Charity Trustee Committee Report** For discussion CTC Report and Annual Review September 16Fi... 7	Chair of CTC	15.05
13.1	**Charity Strategy** For approval 13.1 Charity Strategy.pdf 239	Chair of CTC / Head of Charity	
14	**Data pack** For information	All Directors	
15	**Part II** The Trust Board resolves that under Standing Order 3.17(i) representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the matters to be transacted, publicly which would be prejudicial to the public interest. 14 Data Pack.pdf 255		15:30-18:00
15.1	**Commercial-in-confidence**		
15.2	**Governance Matters**		
15.3	**Personnel Matters**		
16	**Date of next meeting:** 2pm Wednesday 30 November 2016, Board Room, The New QEII Hospital, Welwyn Garden City		

INDEX

05 Draft mins Pt 1.pdf....................7
06 Pt I Draft Actions Log for September 2016.pdf....................15
07 Board Annual Cycle 2016-17 revised new format.pdf....................17
08 Chief Executive's Report.pdf....................21
09.1 Mortality Report Sep-16.pdf....................35
10.1 FPC Report_to_Board_Sept 2016-JA.pdf....................57
10.1.1 Board_Finance Month 5 final post FPC.pdf....................61
10.1.2 September Performance report for FPC_final.pdf....................77
10.1.3 Workforce Report.pdf....................85
11.1 RAQC Report to Board September Final.pdf....................95
12 AC report to board.pdf....................99
12.1 Annual Auditors Letter.pdf....................103
12.2 Standing Financial Instructions-Orders final .pdf....................119
13 CTC Report and Annual Review September 16Final.docx.pdf....................227
13.1 Charity Strategy.pdf....................239
14 Data Pack.pdf....................255

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 27 July 2016 at 2pm at the Mount Vernon Cancer Centre, Rickmansworth Road, Northwood

Present:	Mrs Ellen Schroder	Chair of the Trust Board
	Mrs Alison Bexfield	Non-Executive Director
	Mr Nick Carver	Chief Executive
	Mr John Gilham	Non-Executive Director
	Ms Jane McCue	Medical Director
	Mr Julian Nicholls	Non-Executive Director
	Mr Bob Niven	Non-Executive Director
	Mr Brian Owens	Acting Director of Operations
	Mr Brian Steven	Interim Director of Finance
	Ms Angela Thompson	Director of Nursing
From the Trust:	Ms Jude Archer	Company Secretary
	Mr Joe Maggs	Corporate Governance Officer
	Mr Vijay Patel	Non-Executive Director Designate
	Mr Tom Simons	Director of Workforce and Organisational Development
	Ms Wendy Walker	Assistant Director, Transformation Programme Office

ACTION

16/184 CHAIR'S OPENING REMARKS

16/184.01 The Chair welcomed everyone to the meeting.

16/185 DECLARATIONS OF INTEREST

16/185.01 There were no declarations of interest.

16/186 QUESTIONS FROM THE PUBLIC

16/186.01 The Chair confirmed there were no questions from the public.

16/187 APOLOGIES FOR ABSENCE

16/187.01 Apologies for absence were received from Mr Stephen Posey, Deputy Chief Executive and Director of Strategic Development. Ms Walker deputised for Mr Posey at the meeting.

16/188 MINUTES OF THE PREVIOUS MEETING

16/188.01 The minutes of the meeting held on 29 June 2016 were considered and approved as an accurate record of the meeting subject to minor amendments.

16/189 ACTIONS LOG

16/189.01 The Board noted the Actions Log.

16/190 ANNUAL CYCLE

16/190.01 The Board reviewed the Annual Cycle. Mr Gilham noted that the Cycle indicated that the LTFM had been considered by the Trust Board in June when it had not. It was agreed that the error would be corrected. **Company Secretary**

16/191 **CHIEF EXECUTIVE'S REPORT**

16/191.01 The Chief Executive congratulated Mr Posey, Deputy Chief Executive, on his recent appointment as Chief Executive at Papworth Hospital NHS Foundation Trust. The Board echoed the Chief Executive's congratulations. Mr Posey's time with the Trust would come to end around November and his post was currently being advertised.

16/191.02 The Chief Executive provided an update regarding the appointment of an interim Chief Operating Officer (COO), with further developments having taken place since the publication of his report. He informed the Board that an interim COO had now been appointed and would begin working fulltime within the Trust from the week commencing 8 August. The Chief Executive thanked Mr Owens for his work as Acting Director of Operations whilst the Trust were recruiting to the post. In response to a question from Mr Niven, it was noted that the Trust had now chosen a different agency to recruit to the permanent COO position.

16/191.03 The Board were informed that an offer of employment had been made for the Director of Finance position, following the interviews held on 26 July. This would be subject to the usual checks and it was anticipated that this would be announced by the organisation shortly.

16/191.04 The Chief Executive also highlighted the following items from the report:

- The Trust's AGM had been held on 12 July and feedback from the event had been positive. Mrs Schroder agreed that the event had been a success and noted that there had been a wide variety of stalls.
- The Trust's ARC sessions were drawing to a close and a new programme around the Trust's new leadership model LEND (Listen, Empower, Nurture and Develop) was due to begin.
- The Trust's Academics Foundation Programme Proposal had been accepted by Health Education East of England / Essex Hertfordshire and Bedfordshire School. The Trust would receive four FY1 academic education posts linked with the University of Herts and three FY1 research Cambridge linked posts.
- Kerry Eldridge, Deputy Director of Workforce and OD for the Trust, had been named Deputy HR Director of the Year at the HPMA awards.
- The Trust had achieved success regarding renal research, being noted as the top UK recruiter to the Alpha Study.

16/191.05 Regarding the Trust Floodlight Scorecard, the Medical Director noted that the RAG rating threshold for the SHMI KPI was incorrect. At 109.7, the RAG rating should have been displayed as Amber.

FINANCE AND PERFORMANCE

16/192 **Finance and Performance Committee's Report**

19/192.01 Mr Nicholls (Chair of the Finance and Performance Committee) presented the Committee's report to the Board. At its most recent

meeting, the Committee had approved the Salix Finance Loan Application, subject to affordability. Regarding the Floodlight Scorecard, they had requested future reports include trend data to indicate the direction of travel. The Committee had been informed that clinical income was £1,337k higher than plan and £2,189k higher year-to-date with over-performance on non-electives, day cases and outpatients. The Committee had noted the latest information in relation to the Trust's revised Control Total and Sustainability and Transformation Funding and also noted the significant risks to the delivery of the revised control target and the need to improve the control environment, identify new CIP schemes, reduce agency expenditure and mitigate emerging risks. Regarding the CIP Programme, the Committee had been concerned at the level of unidentified CIP schemes.

16/192.02 The FPC had received an update on Service Line Reporting (SLR). SLR reports would be produced as a core financial reporting tool from November 2016. The Committee had reviewed the top 5 positive and bottom 5 adverse variances from plan. This had highlighted an income and expenditure deficit within Urology and a deep dive would be undertaken to understand the reasons for this. Mrs Schroder commented that the update had been useful and that it was now important to consider how best to use the data. The Interim Director of Finance noted that there were a number of areas with income deficiencies and lessons would be learned from the Urology deep dive. Following this, a small scale version of the deep dive would be considered for other areas.

16/192.03 Mr Nicholls noted that there had been discussion regarding the use of Lean methodology at FPC, but he was concerned that the resource was currently tied into the Lorenzo project and questioned whether there was some value in redirecting the resource. In relation to the increase in elective demand, Mr Nicholls asked whether the Trust's margin on waiting list activity was known. The Interim Director of Finance considered that the margin was not currently known at the level of detail that was needed. Mr Gilham suggested that if the Trust was able to evidence the true cost of the waiting list activity then there could be scope for discussion with the CCG regarding funding. The Interim Director of Finance advised that, in his experience, there was not much financial gain from increased waiting list activity because the associated premiums also increased. Mrs Schroder suggested that the issue could be discussed further once the full figures were available.

16/193 **Finance Report**

16/193.01 The Interim Director of Finance presented the Finance Report. He explained that whilst the Quarter 1 position was positive, with a £1,418k favourable variance from plan, prior to an additional £1,220k contingency, there were significant risks to the delivery of the Trust's revised control target. He also noted that whilst the Trust was reporting a positive position on clinical income, the activity and income position did not appear to be aligned, particularly for non-elective income. This could lead to a later negative or positive adjustment once the reasons were fully known.

16/193.02 The Interim Director of Finance noted that workforce remained a challenge that and it was his intention for the agency premium to be reported in future reports. Regarding increasing demand, he explained that it was important to ensure this was fully understood. If activity was to increase then NHSI would revisit the Trust's

trajectory. Regarding clinical income, there was some concern regarding W&C's, but actions were in place to address this. There was also some concern regarding the CIP programme, with the current CIP forecast indicating a £3.2m shortfall against the £15.5m target. It was reported that there was some contingency available to assist with ensuring quarterly targets were met in the first 6 months. The Board noted the actions in place to work to addressing this gap.

16/193.03 Mrs Schroder asked when a refreshed year-end forecast would be available by, suggesting that the forecast should be shared with the CCG. The Interim Director of Finance advised that the forecast should available by the end of August, in time for the Committee and Board meetings in September. Mr Niven asked whether there was a timetable in place to address the issue with unidentified CIP schemes. The Interim Director of Finance suggested that the task would become more challenging the longer it was left. He suggested that project management resources could be allocated to the work as a means of 'investing to save'.

16/193.04 Mrs Schroder asked what the issues were within the W&C's division. It was reported that the issues were mainly income related and it was confirmed that the division were now meeting on a weekly basis with the Chief Executive to address the issue. A significant amount had already been identified to be recovered. It was also noted however that some issues were out of the Trust's control and would need discussion with the CCG. Mr Nicholls emphasised the importance of tightness in day to day management and of ensuring that the Quarter 3 target was achieved. Mr Gilham queried whether the data for excess bed days in June was correct. The Interim Director of Finance advised that both inpatient elective and non-elective activity were down.

16/194 Performance Report

16/194.01 The Acting Director of Operations presented the Performance Report and informed the Board that the Trust had achieved against the 6 KPIs agreed with the TDA. The RTT target had been achieved in the context of a challenging position nationally. The ED 4 hour wait target trajectory had also been achieved, though it was noted that performance had plateaued to an extent over recent months. The Acting Director of Operations explained that it was the intention to use the Lean/Six Sigma principles to move ED performance further forward. Regarding stroke, it was reported that there had been good progress against the metrics and the Trust was yet to receive any additional patients following the change at Bedford Hospital. Mr Patel queried whether all stroke income was being captured and the Acting Director of Operations explained that this was an area within the Trust where the process was more developed. The cancer target had been achieved for May but was at risk of not being achieved for June. The Acting Director of Operations explained that the increase in referrals remained a significant challenge for this target in particular, with continued growth seen during June. He reported that he had raised the need for help with resourcing with the CCG but was concerned that a number of patients were now 8 weeks into the 18 week target.

16/194.02 Regarding the increased number of referrals, Mrs Schroder asked whether they were all appropriate. The Acting Director of Operations explained that the Trust had undertaken work on the conversion rate and was confident that the process was working. Mr Nicholls asked what the absolute number of referrals was year on year. The Acting

Director of Operations reported that, cumulatively, there had been 5000 extra referrals in the current year against the previous year. The Medical Director asked if there was any evidence that GPs had held onto referrals in April and March. The Acting Director of Operations said there was not, with the increase in referrals coming from across the board. He noted that there had been a change in NICE guidance for cancer referral pathways which may have led to the increase. Mrs Schroder added that the CCG had suggested that the increase might be as a result of risk averse GPs.

16/194.03 Mr Gilham asked if the ED Pathways Project actions had taken place and, if they had, why the full benefits had not materialised. The Acting Director of Operations said that the actions had been delivered on time and some benefits had been seen. He noted that the flow out of ED had improved and the number of patients discharged before midday was increasing. A supportive programme was in place to support a cultural change and team working. It was noted that a preliminary discussion had been held with NHSI around receiving additional support from ECIP (Emergency Care Improvement Programme). The intention was that ECIP would provide a team that worked alongside the Trust until recovery of the national performance standard was maintained. Mrs Schroder asked how the Trust compared nationally against the standard. The Acting Director of Operations explained that the Trust was in the worst performing region. The Medical Director noted that there was a weak linkage in terms of mortality and ED performance.

16/195 Workforce Report

16/195.01 The Director of Workforce and OD presented the Workforce Report. The report provided information on standard monthly metrics and Trust wide issues relating to management of the workforce. Regarding nursing staff, the Director of Workforce informed the Board that he was encouraged by the numbers in the pipeline and reported that new advertising campaigns were due to be launched. He reported that temporary staff numbers were reducing and the unit cost was coming down. The Trust's FFT score for the percentage of staff who would recommend the Trust for work had also significantly improved.

16/195.02 Mr Patel asked whether the ARC programme had led to improvements in the culture KPIs. The Director of Workforce and OD said improvements had been seen and further improvements were targeted for the current year. Mr Niven noted that there had been a large number of staff who did not attend the ESR eform workshops. The Director of Workforce and OD explained that these eforms were being embedded as part of Business As Usual. Mr Niven also asked what the Trust's position was regarding retention. The Director of Workforce and OD said that the Trust performed better than some comparators but expected performance to drop slightly in the short term.

RISK AND QUALITY

16/196 Risk and Quality Committee Report

16/196.01 Mr Gilham (Chair of the Risk and Quality Committee) presented the Committee's report to Board. The Committee had received a report regarding the OCH process which sought to review whether clinical benefits from the process had been realised. The Committee were pleased to note that there was evidence of improvement from a

quality perspective. The Committee had also discussed the impact of demand within ED and noted that an objective assessment of demand for such projects was important. The Committee had been assured by the report and did not consider a further update was needed. The Medical Director added that there was further emerging evidence of clinical quality improvements, noting that there was not yet a full year of data to review.

16/196.02 The Committee had also received a report from the Director of Estates and Facilities looking at the estates capital funding backlog. The Committee had sought to establish whether the programme was driven by capital availability rather than need. A 6 facet survey was scheduled to be completed later in the year which would provide further information regarding the estates priorities. It was agreed that the Committee would receive a further update following the survey. The Committee considered there was a high level of risk in this area. The Interim Director of Finance agreed that the estates capital allocation seemed low. Mr Gilham added that another piece of work around the MVCC estates risks had been requested by the Committee and was scheduled for the meeting in September. Mr Nicholls commented that by focussing on urgent estates items it was likely that there would be a greater deterioration of the estate elsewhere which would lead to more costs in the long run.

16/196.03 Mr Gilham noted that the Committee had approved the Infection Prevention Control (IPC) Annual Report. There had been some issues regarding IPC performance in the current year but these were being addressed. The Committee also received a report regarding the Corporate Risk Register. They had considered that further work was needed in this area and the risk register would be reviewed by Mr Gilham and the Company Secretary in August.

16/197 Nursing Establishment Review

16/197.01 The Director of Nursing presented the Nursing Establishment Review. The data collection for the review had taken place in April 2016. Actual staffing data was reviewed over a 20 day period along with patient acuity data and benchmarking data from other Trusts. It was noted that the three trusts chosen for the benchmarking exercise were different to those the Trust had previously compared against in order to ensure the comparison was robust. The Director of Nursing explained that there would be an external review of ED staffing in September and a Maternity staffing review would also be completed separately. The recommendations set out within the report were to:

- Increase 10B unregistered day coverage from 5+3 to 5+4 on the early and from 4+3 to 4+4 on the late; this is a cost increase of £49,770.

- Increase 11A band 2 CSW night coverage from 5+1 to 5+2 on the night; this is a cost increase of £74,952.

- Convert 1 band 5 RN Post to a band 4 Nursing Associate role on 24 wards (Excluding NICU, Maternity, ICU, and Bluebell) @ a potential annual cost saving of £130,359. This is part of a scoping exercise over the next two years to enable wards to introduce the new Nursing Associate Role and develop clear career pathways.

16/197.02 Mrs Bexfield queried why the Board was required to approve the nursing establishment when it did not do so for other staff groups. The Director of Nursing confirmed that it was a national requirement for nursing staff and the Medical Director noted that there was not the same level of guidance regarding staffing levels for doctors. The Chief Executive agreed that a similar scrutiny of medical staffing would be beneficial. Mr Nicholls suggested that the Trust ought to review whether there was an appropriate allocation of staff by area, noting that the majority of the Trust's costs related to staffing. The Chief Executive suggested that benchmarking of the difficult to recruit posts be reported initially, with the report potentially developing from there to ultimately benchmarking the right size medical workforce. The Interim Director of Finance commented that productivity data in the health industry was not as advanced as elsewhere. It was agreed a report regarding medical staffing would be provided for a future Trust Board meeting. The Board approved the recommendations set out within the report. **Medical Director**

16/198 DATA PACK

16/198.01 The Board noted the Data Pack.

There being no further business the Chairman closed the meeting at 15:56 pm.

Ellen Schroder
Trust Chair

September 2016

(red)	Action has slipped
(amber)	Action is not yet complete but on track
(green)	Action completed
*	Moved with agreement

Agenda item: 6

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG PART I TO SEPTEMBER 2016

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
27 January 2016	16/16.01	NHS revalidation changes	Discuss the possible impact of the NHS revalidation changes on staff attrition, possible actions and communications.	Feb 16: The impact of this will not be fully known until the Trust has 6 months of revalidation data. Following approval by Board date set to Oct 16. June 2016: Interim report provided to RAQC in June which after first 3 months did not indicate there was a higher level of leavers at present due to revalidation. Further update to be provided in October.	Director of Nursing and Director of Workforce and Organisational Development	**October 2016**
30 March 2016	16.074.3	Charity Strategy	Strategy to reduce the pence per pound spent on overheads to be added to the strategy. CTC to consider whether to continue with the lottery (for ethical and commercial reasons). Revised strategy to be brought back to the Board in 6 months once new Head of Charity in post.	May 16: Strategy is scheduled for review by the CTC and Board in September September 2016: On agenda.	Head of Charity	**September 2016**
27 July 2016	16.190.01	Annual Cycle	Annual Cycle to be corrected regarding LTFM.	Completed	Company Secretary	**September 2016**
27 July 2016	16/197.02	Medical Staffing	Report regarding medical staffing to be provided.		Medical Director and Director of Workforce and OD	**November 2016**

Board Annual Cycle 2016-17 – To meet alternate months from September 2016.

Items	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Standing Items											
CEO Report inc Floodlight Scorecard	x	x	x	x	x		x		x		x
Data Pack[i]	x	x	x	x	x		x		x		x
Patient Testimony (Part 2)	x	x	x	x	x		x		x		x
Suspensions (Part 2)	x	x	x	x	x		x		x		x
Committee Reports											
Audit Committee Report		x			x		x		x		x
CTC Report		x			x				x		x
FPC Report [ii]	x	x	x	x	x		x		x		x
FTC Report (as required)											
RAQC Report	x	x	x	x	x		x		x		x
Strategic											
Annual Operating Plan and objectives	x								x		x
Long Term Financial Model			x						X (Moved from June TBC)		
Sustainability and Transformation Plan (STP)			x								
Other Items											
Audit Committee											
Annual Audit Letter					x						
Annual Report and Accounts(Trust), Annual Governance Statement and External Auditor's Report		x									
Audit Committee TOR and Annual Report							X (moved from Sept)				
Quality Account and External Auditor's Report			x								

Board Annual Cycle 2016-17 – To meet alternate months from September 2016.

Items	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
Raising Concerns at Work					x				x		
Review of SO and SFI					x		x				
Charity Trust Committee											
Charity Annual Accounts and Report		x									
Charity Trust TOR and Annual Committee Review					x						
Finance and Performance Committee											
Detailed Analysis of Staff Survey Results	x										
Draft Floodlight Indicators and KPIs		x									
Financial Plan inc CIPs and Capital Plan											x
FPC TOR and Annual Report			x								
IM&T strategy review			x								
Market Report		x			x				x		
Market Strategy Review		x									
Risk and Quality Committee											
Adult Safeguarding and L.D. Annual Report		x									
Board Assurance Framework and review of delivery of objectives	x			x			x		x		
Equality and Diversity Annual Report and WRES.							x				
GMC National Training Survey					x						
Health and Safety Strategy Review				x							
Improving Patient Outcomes Strategy		x									
Mortality	x		x		x				x		x
Nursing and Midwifery Strategy Review					x						
Nursing Establishment Review				x					x		
Patient Experience Strategy Review				x							
Post OCH Quality Benefits Realisation				x							
PQAF / Education report		x									

Board Annual Cycle 2016-17 – To meet alternate months from September 2016.

Items	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
RAQC TOR and Annual Review			x								
Research and Development Annual Review		x									
Responsible Officer Annual Review				x							
Safeguarding Children Annual Review				x							
Serious Incidents Report (Part 2)		x		x	x		x		x		x
Board Development Plan		x									
Shareholder / Formal Contracts											
ENH Pharma (Part 2) [iii]				x					x		
tPP (Part 2)	x	x	x	x	x		x		x		x

[i] The Data Pack will include the Friends and Family Test, Statutory and Mandatory Training Exception Report, Health and Safety Indicators, Nursing Quality Indicators, Finance Data, Performance Data, CQC Outcomes, Workforce Data, Safer Staffing Data and Infection Prevention and Control Data.
[ii] The FPC Report will include the Committee Report, the Finance Report, Performance Report and Workforce Report for the month.
[iii] To include the Annual Governance Review in July

Please note Board Development sessions will be held on the 'even' months. This will support flexibility for the Board to be able to be convened for an extraordinary meeting if an urgent decision is required. However forward agenda planning will aim to minimise this.

EAST AND NORTH HERTFORDSHIRE NHS TRUST

CHIEF EXECUTIVE'S REPORT

28th September 2016

1 Director and Non-Executive Director appointments

Martin Armstrong, currently director of finance, information and performance at the North Middlesex University Hospital Trust, has agreed to become the Trust's new finance director; he joins us on 31 October 2016.

As a long-standing, successful finance director, Martin brings with him a wealth of experience and expertise at a time of great challenge and opportunity for the Trust and wider health service.

Val Moore has also been appointed as one of the Trust's non-executive directors. Val, who is also the chair of Healthwatch Cambridgeshire, will serve on the Trust's Board for a four-year period from 1 September 2016 to 31 August 2020.

Bernie Bluhm has joined the Trust in the interim role Chief Operating Officer whilst the recruitment process proceeds to secure a substantive appointment.

Interviews will be held on 27th September for a substantive Chief Operating Officer.

Interviews for the Trust's next Director of Strategy took place on 22nd September.

2 System Transformation Programme

Work has progressed with partners across the system to develop the Sustainability and Transformation Plan for Hertfordshire and West Essex. The developing plan has several work streams established, one of which is the acute work stream for which I am the chief executive lead.

This provides an opportunity to work in partnership across the system and develop collaborative solutions to support the sustainability of local services provided across the Trust, Princess Alexandra Harlow NHS Trust and West Hertfordshire Hospitals NHS Trust. A Programme Board has been established to steer this work and oversee an initial five specific priority projects with input from clinical colleagues across Hertfordshire and West Essex.

3 Care Quality Commission (CQC) update

On 17th May, the CQC conducted an unannounced visit which focused on the Lister's emergency department and Bluebell ward. Verbal feedback received at the time confirmed that substantial, sustained improvements were demonstrated in both areas.

The CQC has now published its report which reflects the verbal feedback that was given. The CQC states clearly in the report that its inspectors found good progress had been made by both the children's ward and emergency department teams against the areas where further work was requested.

Of course more needs to be done, but it is good to see that the CQC inspection team could see that real progress has been made since last October – but we should not let this detract from

the very real progress that has been made in these areas. That is testament to the great efforts made by our staff to ensure that they responded quickly and positively to the CQC inspection.

This report does not affect our original ratings – we are expecting that the CQC will visit us again at a later date for a more formal review of our services that may lead to a revision of our ratings.

The report can be found on the CQC's website at http://www.cqc.org.uk/location/RWH01.

4 Recruitment pilot – band 5 and 6 nurses

The Trust has launched a new recruitment pilot aimed at encouraging band 5 & 6 nurses working via agencies to re-join the NHS.

This pilot gives new recruits the choice of whether to enhance their pay, or a choice of two pension schemes (NEST and the normal NHS pension). All new starters will be auto-enrolled in a pension but will be given the choice to enhance their pay or stay part of the pension.

The Trust is keen to encourage staff to remain part of the NHS pension although it recognises that some agency staff have already made the choice to receive higher pay and thus this initiative may prove useful in attracting them back to the NHS. However, the initiative has to be made available to the same group of internal staff for equal pay reasons. The initiative will be reviewed after 6 months.

5 Junior Doctors Industrial Action

In light of the planned industrial action by junior doctors, operational plans are being developed to ensure that a safe, high quality emergency service is maintained during the proposed periods of industrial action.

The planned strikes represent an escalation, with each of the proposed actions covering five days. The October dates are likely to be especially challenging as the strike is planned from Wednesday 5th October until Friday 7th and then recommences after the weekend for a further two days. This is the first time that the strike has impacted prior to and immediately after a weekend.

Additional industrial action is planned for 14th -18th November and 5th – 9th December.

During the strikes, non-emergency clinics and some theatre cases will be cancelled, however emergency services will continue. It is anticipated that the volume of cancelled cases will be comparable to the levels cancelled during the last two days of previous strikes. Therefore for each block of action the Trust is likely to cancel c.2,300 outpatient appointments and c.85 operations.

Cancelling this volume of activity will increase the risk to the 18 week RTT and cancer standards in future months unless this activity can be made up later in the year.

Contingency planning is underway and consultants will be deployed into key emergency areas to ensure that safe emergency care is provided. The planning includes the wider health system - partner organisations will be working to mitigate the volume of patients attending the hospital

and to ensure that processes and resources are available to ensure the timely discharge of patients into community settings.

Whilst mitigating actions will be in place, this round of industrial action will result in large

volumes of non-emergency patients having delays in their appointments and treatments.

6 Trust awards: Celebration of Excellence staff awards

On Friday 23rd September, over 300 members of the team will come together at Tewin Bury Farm for the Trust's long server and staff awards. 200 nominations were received – the highest number ever. I will provide a verbal update on staff award category winners at the Board meeting.

30 staff who have been with the Trust for more than 25 years were invited to receive certificates and vouchers, and prizes will be handed out to 12 individuals and teams in recognition of their outstanding work.

7 Trust awards: medical education awards

The Trust's poster competition has been running for four years. 18 judges worked to select three posters out of 48 submitted. The winners were invited to present at the last Grand Round of the academic year and the best poster was chosen by the audience.

1st place - Cadaveric simulation: A new development at the Lister Education Centre (LEC) - Monem M, Kirby C, Harris A, Metcalfe M

2nd place - Treatment Escalation Pathway - Kloczko E and McNaughton E

3rd place - Temocillin Use in Renal Patients in a Large District Hospital: A retrospective study on the clinical effectiveness and outcomes of temocillin in patients with renal disorders - Scott R, Morlidge C, Ladenheim D, Mathavakkannan S, Kandil H

The Trust's 'Trainer of the Year' award has now been running for three years and nominations are invited from trainee forum, consultants and trainees. The shortlisting is discussed by a subgroup of the Trust Education Board and the final decisions are based on nominations as well as involvement in the Trust's educational activities.

Winner - Dr Anshoo Dhelaria, Paediatrics

Runners up - Dr Rupe Deol, T&O and Dr Nasser Khan, Gastroenterology

The Trust's 'Educational Department of the Year' award is based on the GMC's Trainee Survey results as well as the support to wider education in the Trust.

Winner - Nephrology

Runner up – Elderly Medicine

I would like to thank all those involved for their commitment to their colleagues, the Trust and their patients.

8 Plenty to be proud of week 26th - 30th September

The Trust is carrying out a range of initiatives during this week to celebrate the commitment and achievements of our team. Activities include a chapel service at the Lister, social media work and information on the Knowledge Centre. Departments have also been encouraged to celebrate their staff locally.

9 Chief Executive's road shows

We are part-way through a series of road shows, designed to give staff the opportunity to receive an update on performance and demand, finance and patient feedback. The content also includes a reminder about the CQC and the sources of support available to staff.

The road shows also give staff the opportunity to ask questions. All staff are invited, and events are taking place at all four main hospital sites, the four renal satellite units, the health records facility and Wiltron House.

10 Trust signs up to Hertfordshire Compact

The Trust has recently signed up to the Hertfordshire Compact which is a written understanding between the voluntary and community sector and statutory sectors about how they will co-operate and continue to develop positive working relationships for the benefit of Hertfordshire's communities.

The Compact process is one of learning, development and dialogue. We are delighted to support the Hertfordshire Compact as it enables us to continue to develop our relationship with voluntary and community sector providers as well as the many patient and community groups we work with. For more information on what this could mean for our services please contact David Brewer in the first instance.

11 National Rheumatoid Arthritis Society (NRAS) Award

Having been nominated by one of their patients, Fidelma Gordon, Sharon Pearson and Alex Greengrass from the Trust's rheumatology team have received a Health Care Champion Award from NRAS. They have also been invited to a later awards ceremony at the House of Commons, where awards will be presented by NRAS patron, the Prime Minister, the Rt. Hon. Teresa May.

12 UCL Medical School: Quality Assurance Unit 'Top Teacher' Awards

Students of the UCL Medical School are asked to nominate teachers and administrators who they have found to be particularly helpful or inspiring.

Caroline Kirby, undergraduate clinical skills tutor, and Dr Mary Lynch, cardiology consultant, were singled out for praise by the students and have been awards Top teacher certificates.

13 Quality in Care Diabetes 2016 Awards

The Trust's diabetes service for adolescents and young adults has been selected as a finalist in the Quality in Care Diabetes 2016 Awards.

The awards presentation will be held on Thursday 13th October.

14 Executive Committee Summary Report to Board

Performance & Projects

The Committee has continued to provide scrutiny to areas of service development, performance (quality, safety, patient experience, performance targets), operational pressures including ward staffing and emergency department performance, finance, mortality, hospital

acquired infections, and key strategic contracts and projects and workforce planning. Further detail is within the performance report.

The Committee have reviewed and agreed an approach for informing the commissioning intentions and contracting 2017-2019. The deadline to agree contracts for the two financial years is set for 31 December 2016, 3 months earlier than usual covering 24 months as opposed to 12 months.

The Financial Recovery Board is now fully integrated into the Executive Committee/Divisional Executive Committee progressing key projects.

The key areas for escalation are included in the Director reports to Board and Board Committees.

Floodlight Scorecard

The month five Trust floodlight scorecard is attached ***(Appendix A)*** and includes the new targets and agreed thresholds for 2016/17. Explanation of red indicators is provided within the appropriate accountable Director's report and the reports in the data pack. The Board committee executive summary reports reflect the key discussions that have taken place at both the Finance and Performance and the Risk and Quality Committees.

Chief Executive
23rd September 2016

TRUST FLOODLIGHT

DASHBOARD AND SCORECARD 2016/17

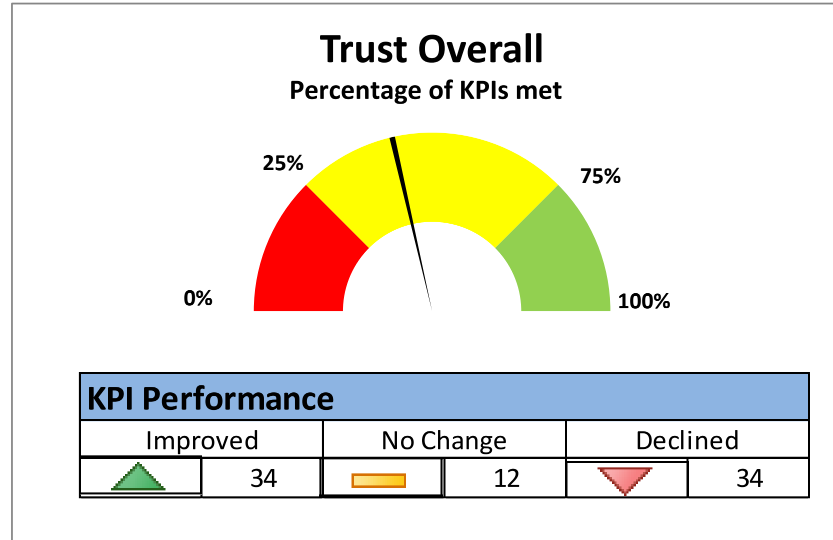
August 2016 - Month 5

The Purpose of this report is to give an overview of Key Performance Indicators (KPI's) which the Trust have agreed to measure and monitor throughout 2016/17.
The indicators compare to monthly and year-to-date performance targets scoped within quarter 1 of this financial year.
The intended audience is the Executive Team, Operations and Governing Bodies to support strategic design making and identify emerging issues across the Trust.

GUIDANCE

Executive Summary	• Overview of the Trusts performance when compared to targets and historical performance
Dashboard	• High-level visualisation of the Key Performance Indicator Themes grouped to give an indication of overall performance
All KPI's by Theme	• Second level of detail of agree Key Performance Indicators showing change in performance when compared to the previous month.
Trust Floodlight Scorecard	• Further detail on KPI's showing both monthly and year to date performance RAG to in-month and yet-to-date targets with change when compared to the previous month
Scorecard 2016/17	• Full detail of the Key Performance Indicators showing month-on-month performance
Targets 2016/17	• Target and threshold set by the Trust for ease of reference.
Data Dictionary	• Link to the Trust Floodlight Data Dictionary which gives detail of how the Key Performance Indicator is calculated, any exceptions, where the information is sourced, system and so on.

Executive Summary August 2016



KPI Performance					
Improved		No Change		Declined	
▲	34	▬	12	▼	34

Executive Summary

RTT – achieved national standard in month, with STF trajectory also achieved.

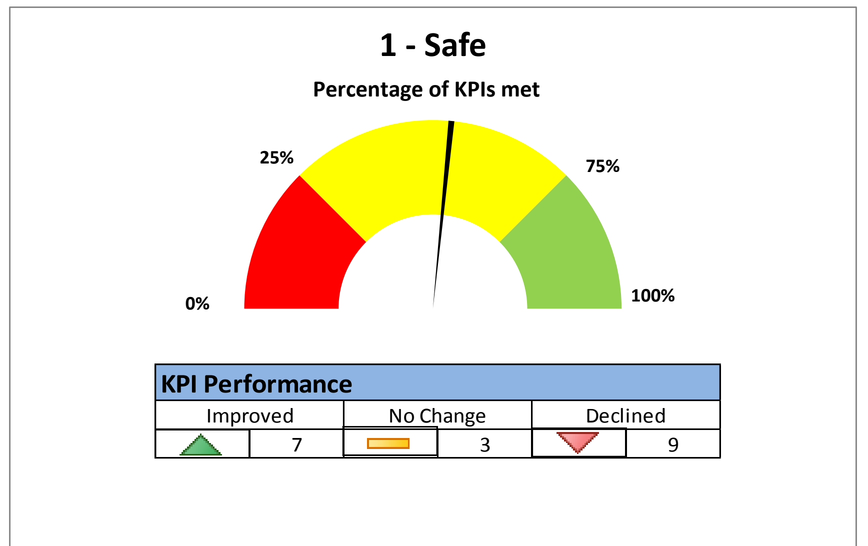
A&E – did not achieve the 4 hour standard in August, but did achieve the STF trajectory. September performance is now unlikely to achieve STF. The improvement programme has been revised including the national priorities, and now also includes the implementation of red/green days.

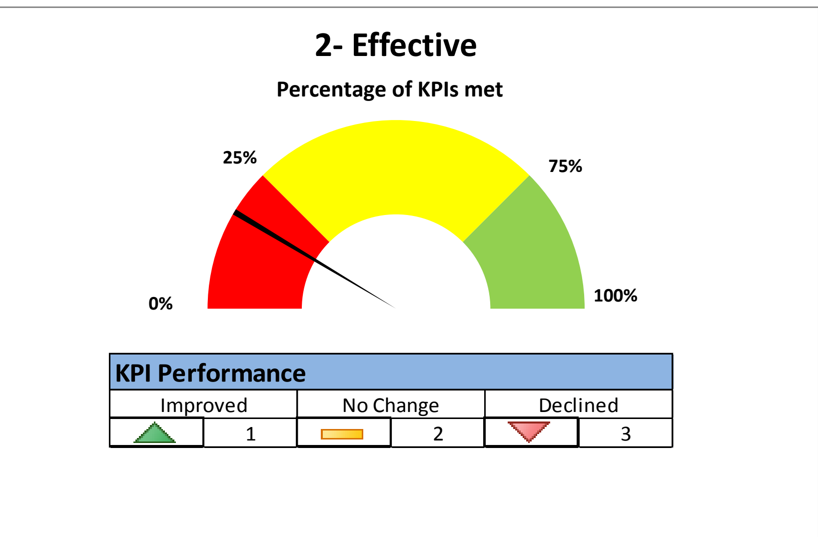
Cancer (July) – did not achieve the 62 day standard, and the trajectory has been revised to demonstrate how the actions documented in the plan, recover the position, ie back to achievement. Strategic Cancer Network completed their review of our service on 14th Sept; on the day feedback was positive with strong clinical engagement.

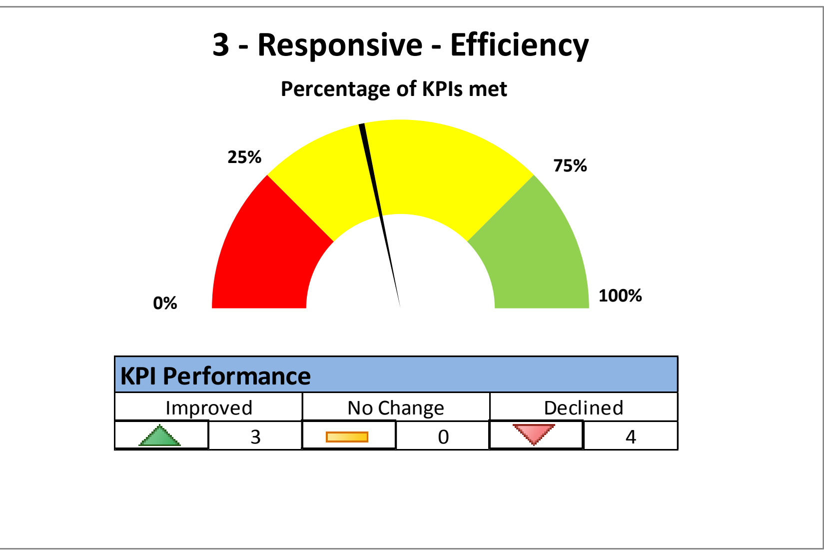
Diagnostics – achieved standard in August.

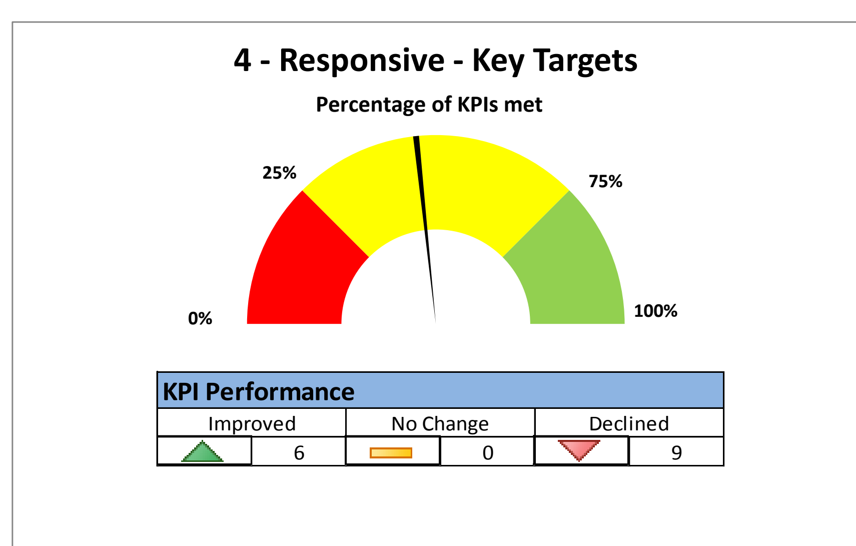
Stroke - 91% delivered for 4hrs in August with 67 confirmed strokes. This is the first time the stroke unit has achieved the 4hr target.

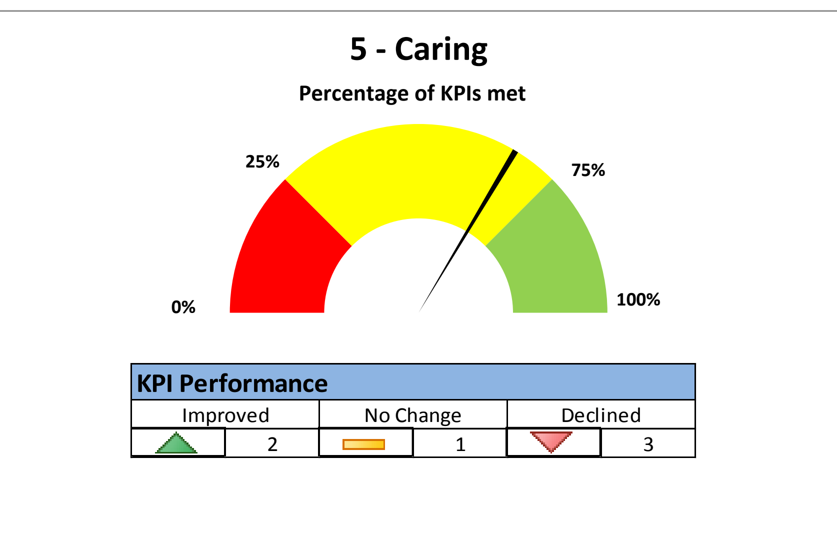
Trust Floodlights Dashboard
August 2016 (M5)

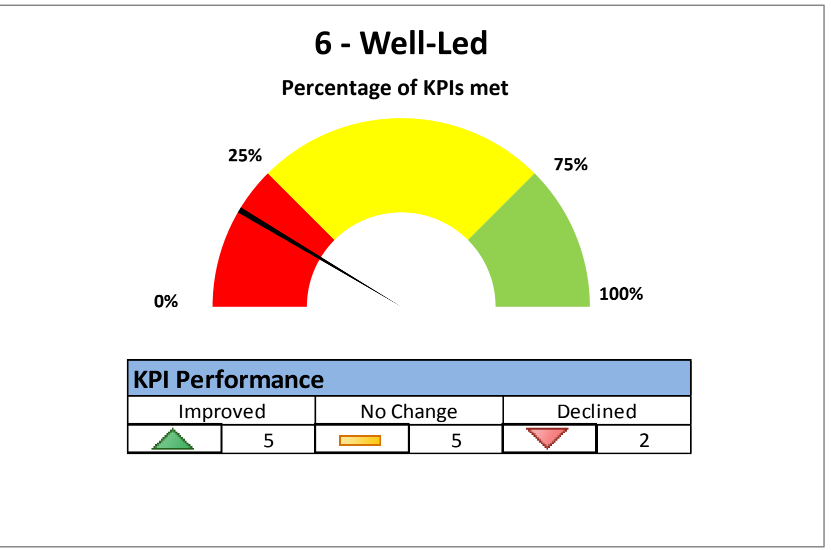


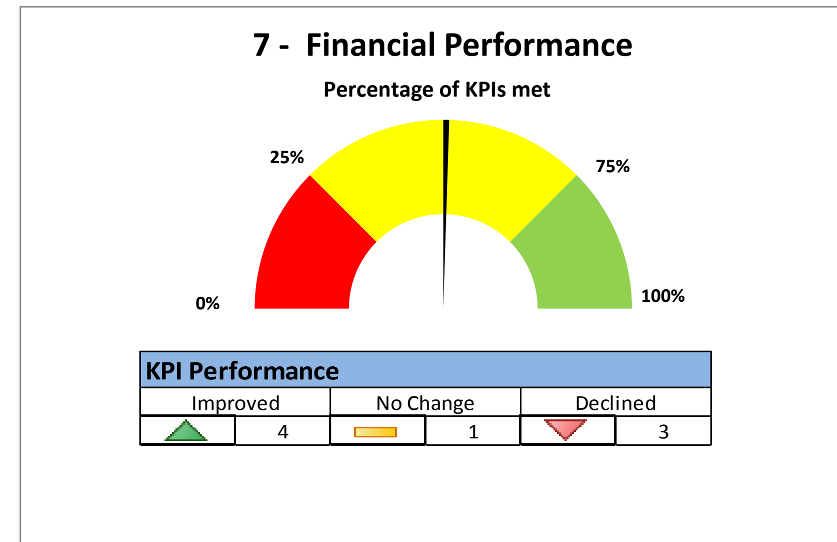


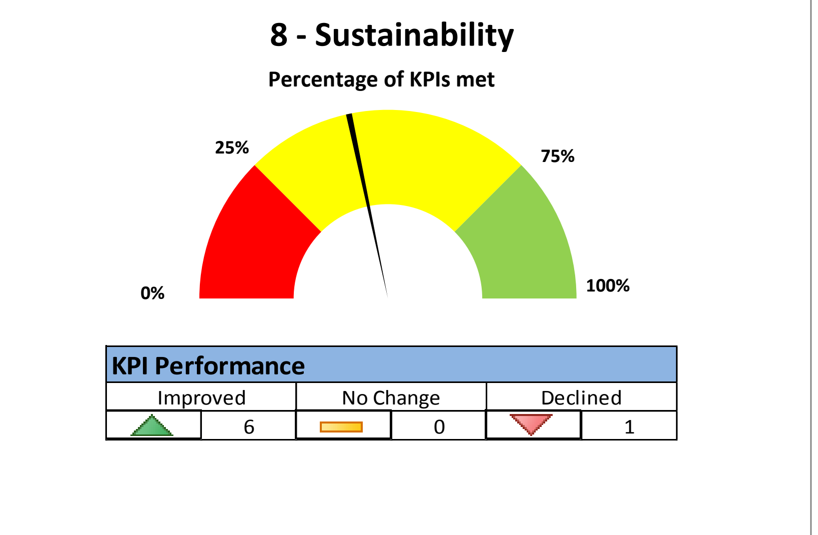




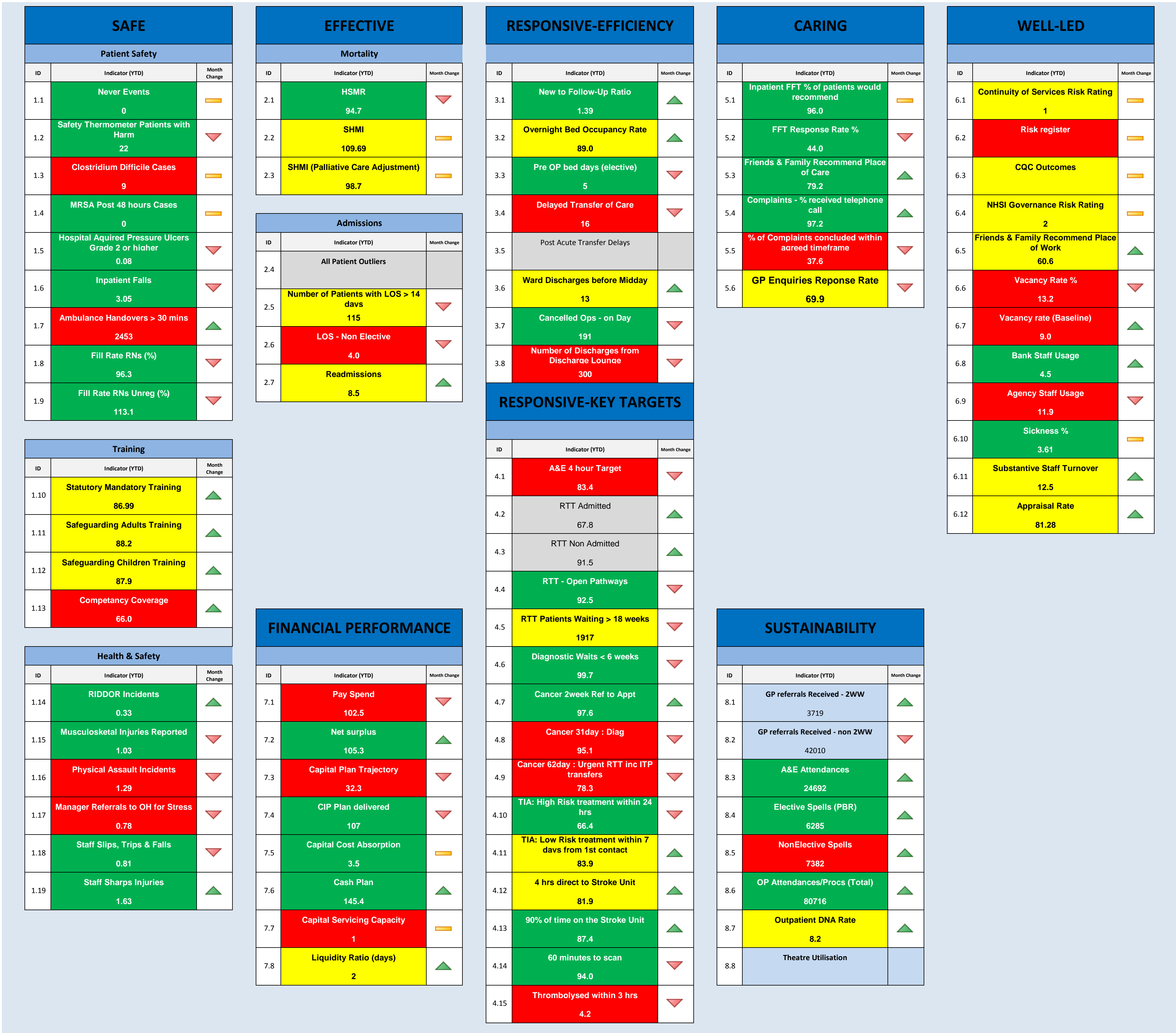








Year to Date Performance



SAFE

Patient Safety

ID	Indicator (YTD)		Month Change
1.1	Never Events	0	▬
1.2	Safety Thermometer Patients with Harm	22	▼
1.3	Clostridium Difficile Cases	9	▬
1.4	MRSA Post 48 hours Cases	0	▬
1.5	Hospital Aquired Pressure Ulcers Grade 2 or higher	0.08	▼
1.6	Inpatient Falls	3.05	▼
1.7	Ambulance Handovers > 30 mins	2453	▲
1.8	Fill Rate RNs (%)	96.3	▼
1.9	Fill Rate RNs Unreg (%)	113.1	▼

Training

ID	Indicator (YTD)		Month Change
1.10	Statutory Mandatory Training	86.99	▲
1.11	Safeguarding Adults Training	88.2	▲
1.12	Safeguarding Children Training	87.9	▲
1.13	Competancy Coverage	66.0	▲

Health & Safety

ID	Indicator (YTD)		Month Change
1.14	RIDDOR Incidents	0.33	▲
1.15	Musculosketal Injuries Reported	1.03	▼
1.16	Physical Assault Incidents	1.29	▼
1.17	Manager Referrals to OH for Stress	0.78	▼
1.18	Staff Slips, Trips & Falls	0.81	▼
1.19	Staff Sharps Injuries	1.63	▲

EFFECTIVE

Mortality

ID	Indicator (YTD)		Month Change
2.1	HSMR	94.7	▼
2.2	SHMI	109.69	▬
2.3	SHMI (Palliative Care Adjustment)	98.7	▬

Admissions

ID	Indicator (YTD)		Month Change
2.4	All Patient Outliers		
2.5	Number of Patients with LOS > 14 days	115	▼
2.6	LOS - Non Elective	4.0	▼
2.7	Readmissions	8.5	▲

RESPONSIVE-EFFICIENCY

ID	Indicator (YTD)		Month Change
3.1	New to Follow-Up Ratio	1.39	▲
3.2	Overnight Bed Occupancy Rate	89.0	▲
3.3	Pre OP bed days (elective)	5	▼
3.4	Delayed Transfer of Care	16	▼
3.5	Post Acute Transfer Delays		
3.6	Ward Discharges before Midday	13	▲
3.7	Cancelled Ops - on Day	191	▼
3.8	Number of Discharges from Discharge Lounge	300	▼

RESPONSIVE-KEY TARGETS

ID	Indicator (YTD)		Month Change
4.1	A&E 4 hour Target	83.4	▼
4.2	RTT Admitted	67.8	▲
4.3	RTT Non Admitted	91.5	▲
4.4	RTT - Open Pathways	92.5	▼
4.5	RTT Patients Waiting > 18 weeks	1917	▼
4.6	Diagnostic Waits < 6 weeks	99.7	▼
4.7	Cancer 2week Ref to Appt	97.6	▲
4.8	Cancer 31day : Diag	95.1	▼
4.9	Cancer 62day : Urgent RTT inc ITP transfers	78.3	▼
4.10	TIA: High Risk treatment within 24 hrs	66.4	▼
4.11	TIA: Low Risk treatment within 7 days from 1st contact	83.9	▲
4.12	4 hrs direct to Stroke Unit	81.9	▲
4.13	90% of time on the Stroke Unit	87.4	▲
4.14	60 minutes to scan	94.0	▼
4.15	Thrombolysed within 3 hrs	4.2	▼

CARING

ID	Indicator (YTD)		Month Change
5.1	Inpatient FFT % of patients would recommend	96.0	▬
5.2	FFT Response Rate %	44.0	▼
5.3	Friends & Family Recommend Place of Care	79.2	▲
5.4	Complaints - % received telephone call	97.2	▲
5.5	% of Complaints concluded within agreed timeframe	37.6	▼
5.6	GP Enquiries Reponse Rate	69.9	▼

WELL-LED

ID	Indicator (YTD)		Month Change
6.1	Continuity of Services Risk Rating	1	▬
6.2	Risk register		▬
6.3	CQC Outcomes		▬
6.4	NHSI Governance Risk Rating	2	▬
6.5	Friends & Family Recommend Place of Work	60.6	▲
6.6	Vacancy Rate %	13.2	▼
6.7	Vacancy rate (Baseline)	9.0	▲
6.8	Bank Staff Usage	4.5	▲
6.9	Agency Staff Usage	11.9	▼
6.10	Sickness %	3.61	▬
6.11	Substantive Staff Turnover	12.5	▲
6.12	Appraisal Rate	81.28	▲

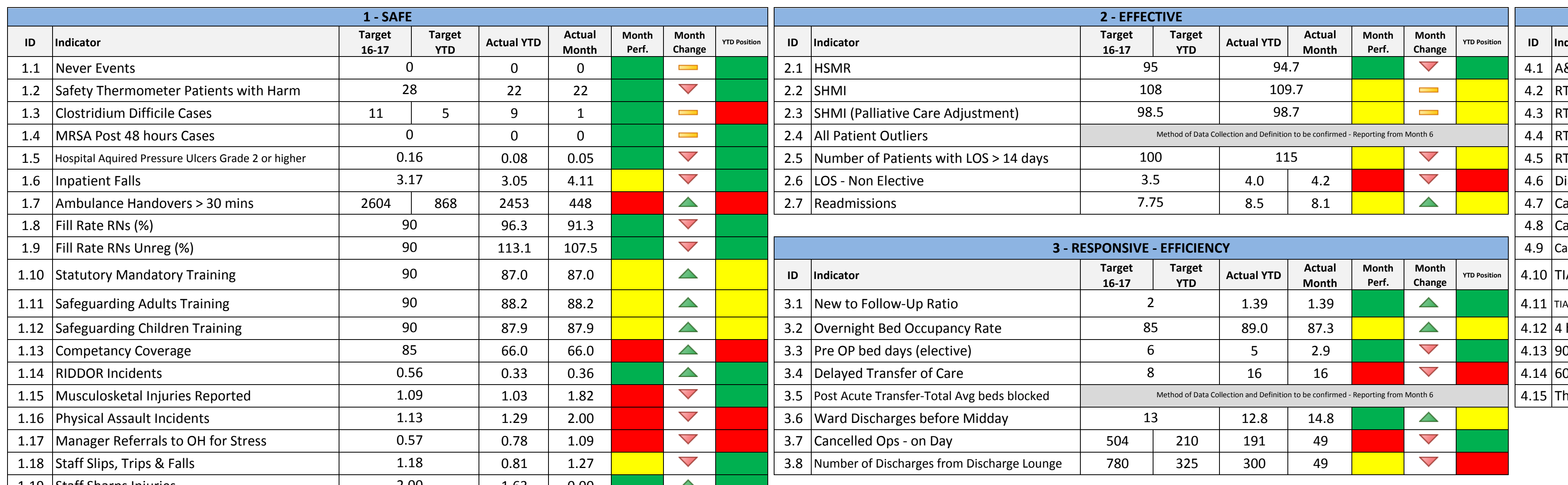
FINANCIAL PERFORMANCE

ID	Indicator (YTD)		Month Change
7.1	Pay Spend	102.5	▼
7.2	Net surplus	105.3	▲
7.3	Capital Plan Trajectory	32.3	▼
7.4	CIP Plan delivered	107	▼
7.5	Capital Cost Absorption	3.5	▬
7.6	Cash Plan	145.4	▲
7.7	Capital Servicing Capacity	1	▬
7.8	Liquidity Ratio (days)	2	▲

SUSTAINABILITY

ID	Indicator (YTD)		Month Change
8.1	GP referrals Received - 2WW	3719	▲
8.2	GP referrals Received - non 2WW	42010	▼
8.3	A&E Attendances	24692	▲
8.4	Elective Spells (PBR)	6285	▲
8.5	NonElective Spells	7382	▲
8.6	OP Attendances/Procs (Total)	80716	▲
8.7	Outpatient DNA Rate	8.2	▲
8.8	Theatre Utilisation		

Trust Floodlights Dashboard
August 2016 (M5)



1 - SAFE

ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
1.1	Never Events	0		0	0		▬	
1.2	Safety Thermometer Patients with Harm	28		22	22		▼	
1.3	Clostridium Difficile Cases	11	5	9	1		▬	
1.4	MRSA Post 48 hours Cases	0		0	0		▬	
1.5	Hospital Aquired Pressure Ulcers Grade 2 or higher	0.16		0.08	0.05		▼	
1.6	Inpatient Falls	3.17		3.05	4.11		▼	
1.7	Ambulance Handovers > 30 mins	2604	868	2453	448		▲	
1.8	Fill Rate RNs (%)	90		96.3	91.3		▼	
1.9	Fill Rate RNs Unreg (%)	90		113.1	107.5		▼	
1.10	Statutory Mandatory Training	90		87.0	87.0		▲	
1.11	Safeguarding Adults Training	90		88.2	88.2		▲	
1.12	Safeguarding Children Training	90		87.9	87.9		▲	
1.13	Competancy Coverage	85		66.0	66.0		▲	
1.14	RIDDOR Incidents	0.56		0.33	0.36		▲	
1.15	Musculosketal Injuries Reported	1.09		1.03	1.82		▼	
1.16	Physical Assault Incidents	1.13		1.29	2.00		▼	
1.17	Manager Referrals to OH for Stress	0.57		0.78	1.09		▼	
1.18	Staff Slips, Trips & Falls	1.18		0.81	1.27		▼	
1.19	Staff Sharps Injuries	2.00		1.63	0.00		▲	

2 - EFFECTIVE

ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
2.1	HSMR	95		94.7			▼	
2.2	SHMI	108		109.7			▬	
2.3	SHMI (Palliative Care Adjustment)	98.5		98.7			▬	
2.4	All Patient Outliers	Method of Data Collection and Definition to be confirmed - Reporting from Month 6						
2.5	Number of Patients with LOS > 14 days	100		115			▼	
2.6	LOS - Non Elective	3.5		4.0	4.2		▼	
2.7	Readmissions	7.75		8.5	8.1		▲	

3 - RESPONSIVE - EFFICIENCY

ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
3.1	New to Follow-Up Ratio	2		1.39	1.39		▲	
3.2	Overnight Bed Occupancy Rate	85		89.0	87.3		▲	
3.3	Pre OP bed days (elective)	6		5	2.9		▼	
3.4	Delayed Transfer of Care	8		16	16		▼	
3.5	Post Acute Transfer-Total Avg beds blocked	Method of Data Collection and Definition to be confirmed - Reporting from Month 6						
3.6	Ward Discharges before Midday	13		12.8	14.8		▲	
3.7	Cancelled Ops - on Day	504	210	191	49		▼	
3.8	Number of Discharges from Discharge Lounge	780	325	300	49		▼	

4 - RESPONSIVE - KEY TARGETS

ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
4.1	A&E 4 hour Target	95		83.4	82.5		▼	
4.2	RTT Admitted	90		67.8	69.6		▲	
4.3	RTT Non Admitted	95		91.5	90.6		▲	
4.4	RTT - Open Pathways	92		92.5	92.5		▼	
4.5	RTT Patients Waiting > 18 weeks	1231		1917	1917		▼	
4.6	Diagnostic Waits < 6 weeks	99		99.7	99.5		▼	
4.7	Cancer 2week Ref to Appt	93		97.6	97.9		▲	
4.8	Cancer 31day : Diag	96		95.1	94.3		▼	
4.9	Cancer 62day : Urgent RTT inc ITP transfers	85		78.3	73.5		▼	
4.10	TIA: High Risk treatment within 24 hrs	62.5		66.4	63.3		▼	
4.11	TIA: Low Risk treatment within 7 days from 1st contact	85		83.9	88.9		▲	
4.12	4 hrs direct to Stroke Unit	90		81.9	91.0		▲	
4.13	90% of time on the Stroke Unit	80		87.4	91.0		▲	
4.14	60 minutes to scan	90		94.0	89.5		▼	
4.15	Thrombolysed within 3 hrs	12		4.2	3.3		▼	

5 - CARING

ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
5.1	Inpatient FFT % of patients would recommend	95		96.0	96.0		▬	
5.2	FFT Response Rate %	40		44.0	44.0		▼	
5.3	Friends & Family Recommend Place of Care	77		79.2	79.2		▲	
5.4	Complaints - % received telephone call	85		97.2	99.0		▲	
5.5	% of Complaints concluded within agreed timeframe	75		37.6	34.0		▼	
5.6	GP Enquiries Reponse Rate	95		69.9	69.9		▼	

6 - WELL-LED

ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
6.1	Continuity of Services Risk Rating	3		1	0		▬	
6.2	Risk register	1		3	0		▬	
6.3	CQC Outcomes	1		2	0		▬	
6.4	NHSI Governance Risk Rating	4		2	0		▬	
6.5	Friends & Family Recommend Place of Work	62		60.64	60.64		▲	
6.6	Vacancy Rate %	10		13.23	13.23		▼	
6.7	Vacancy rate (Baseline)	3.75		8.98	8.98		▲	
6.8	Bank Staff Usage	9		4.5	4.5		▲	
6.9	Agency Staff Usage	7		11.9	11.9		▼	
6.10	Sickness %	3.5		3.61	3.61		▬	
6.11	Substantive Staff Turnover	11		12.51	12.51		▲	
6.12	Appraisal Rate	90		81.28	81.28		▲	

7 - FINANCIAL PERFORMANCE

ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
7.1	Pay Spend	100		102.5	102.5		▼	
7.2	Net surplus	100		105.3	108		▲	
7.3	Capital Plan Trajectory	90		32.3	33.5		▼	
7.4	CIP Plan delivered	100		107	99		▼	
7.5	Capital Cost Absorption	3.5		3.5	3.5		▬	
7.6	Cash Plan	90		145.4	145.4		▲	
7.7	Capital Servicing Capacity	3		1	1		▬	
7.8	Liquidity Ratio (days)	3		2	2		▲	

8 - SUSTAINABILITY

ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
8.1	GP referrals Received - 2WW			3719	908		▲	
8.2	GP referrals Received - non 2WW			42010	7900		▼	
8.3	A&E Attendances	147144	24567	24692	13094		▲	
8.4	Elective Spells (PBR)	37060	6034	6285	3102		▲	
8.5	NonElective Spells	46703	7575	7382	3847		▲	
8.6	OP Attendances/Procs (Total)	471770	76758	80716	40500		▲	
8.7	Outpatient DNA Rate	8		8.19184	7.97396		▲	
8.8	Theatre Utilisation	Method of Data Collection and Definition to be confirmed - Reporting from Month 6						

Key: Monthly Change

▲	Improvement in monthly performance
▬	Monthly performance remains constant
▼	Deterioration in monthly performance

Trust Floodlight Scorecard - The Scorecard shows a summary of performance against each KPI. The KPIs are displayed in the KPI Groups and contain the details of the Target set for 2016/17 and the Target YTD if this is different. The Actual YTD and Actual month performance are detailed separately even if the YTD is the same as the monthly figure. The RAG rating for the month is derived from comparing the monthly reported data against the monthly target. the Month change indicator reflects whether performance has improved, stayed the same or declined when compared to last month. the RAG for YTD is a comparison of the YTD performance for the KPI against the target levels.

Trust Floodlights Dashboard
August 2016 (M5)

Monthly Information, Performance and RAG Rating

1 - SAFE

ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
1.1	Never Events	0		0	0				0	0	0	0	0							
1.2	Safety Thermometer Patients with Harm	28		22	22				35	30	20	18	22							
1.3	Clostridium Difficile Cases	11	5	9	1				3	2	2	1	1							
1.4	MRSA Post 48 hours Cases	0		0	0				0	0	0	0	0							
1.5	Hospital Aquired Pressure Ulcers Grade 2 or higher	0.16		0.08	0.05				0.185	0	0.141	0.045	0.047							
1.6	Inpatient Falls	3.17		3.05	4.11				3.38	2.22	2.58	3.02	4.11							
1.7	Ambulance Handovers > 30 mins	2604	868	2453	448				948	567	490	448								
1.8	Fill Rate RNs (%)	90		96	91				99.0	99.0	97.0	95.0	91.3							
1.9	Fill Rate RNs Unreg (%)	90		113	108				117.0	117.0	112.0	112.0	107.5							
1.10	Statutory Mandatory Training	90		87.0	87.0				61.4	87.7	87.1	85.5	87.0							
1.11	Safeguarding Adults Training	90		88.2	88.2				87.0	89.0	88.5	86.3	88.2							
1.12	Safeguarding Children Training	90		87.9	87.9				87.0	89.0	88.5	86.8	87.9							
1.13	Competancy Coverage	85		66.0	66.0				85.8	64.2	63.8	63.6	66.0							
1.14	RIDDOR Incidents	0.56		0.33	0.36				0.00	0.38	0.37	0.54	0.36							
1.15	Musculosketal Injuries Reported	1.09		1.03	1.82				0.94	0.38	1.28	0.73	1.82							
1.16	Physical Assault Incidents	1.13		1.29	2.00				0.57	1.88	0.73	1.27	2.00							
1.17	Manager Referrals to OH for Stress	0.57		0.78	1.09				0.75	1.51	0.55	0.00	1.09							
1.18	Staff Slips, Trips & Falls	1.18		0.81	1.27				0.75	0.38	0.91	0.73	1.27							
1.19	Staff Sharps Injuries	2.00		1.63	0.00				1.51	2.82	2.01	1.81	0.00							

2 - EFFECTIVE

ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
2.1	HSMR	95.0		94.7					92.4	93.3	91.5	91.5	94.7							
2.2	SHMI	108		109.7					111.3	111.3	109.7	109.7	109.7							
2.3	SHMI (Palliative Care Adjustment)	98.5		98.7					99.6	99.6	98.7	98.7	98.7							
2.4	All Patient Outliers	Method of Data Collection and Definition to be confirmed - Reporting from Month 6																		
2.5	Number of Patients with LOS > 14 days	100		115					134	130	124	113	115							
2.6	LOS - Non Elective	3.5		4.0	4.2				4.3	3.9	3.9	3.7	4.2							
2.7	Readmissions	7.75		8.54	8.1				8.2	9.1	8.4	9.0	8.1							

3 - RESPONSIVE - EFFICIENCY

ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
3.1	New to Follow-Up Ratio	2.0		1.39	1.39				2.22	2.22	2.21	2.21	1.39							
3.2	Overnight Bed Occupancy Rate	85		89.05	87.30				91.2	87.7	89.3	89.7	87.3							
3.3	Pre OP bed days (elective)	6		5.00	2.9				3.9	6.1	1.8	2.5	2.9							
3.4	Delayed Transfer of Care	8		16	16				13	9	15	16								
3.5	Post Acute Transfer-Total Avg beds blocked	Method of Data Collection and Definition to be confirmed - Reporting from Month 6																		
3.6	Ward Discharges before Midday	13.0		12.8	14.8				11.8	11.5	12.6	13.4	14.8							
3.7	Cancelled Ops - on Day	504	210	191	49				36	24	43	39	49							
3.8	Number of Discharges from Discharge Lounge	780	325	300	49				66	69	58	58	49							

4 - RESPONSIVE - KEY TARGETS

ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
4.1	A&E 4 hour Target	95		83.4	82.5				81.1	84.7	84.7	84.2	82.5							
4.2	RTT Admitted	90		67.8	69.6				61.9	69.1	68.9	69.4	69.6							
4.3	RTT Non Admitted	95		91.5	90.6				91.3	92.8	92.8	89.8	90.6							
4.4	RTT - Open Pathways	92		92.5	92.5				92.7	92.9	92.6	92.8	92.5							
4.5	RTT Patients Waiting > 18 weeks	1231		1917	1917				1891	1886	1921	1864	1917							
4.6	Diagnostic Waits < 6 weeks	99		99.7	99.5				99.87	99.74	99.67	99.74	99.52							
4.7	Cancer 2week Ref to Appt	93		97.6	97.9				96.7	97.5	97.4	97.9	96.7							
4.8	Cancer 31day : Diag	96		95.1	94.3				94.8	95.9	94.9	94.3	97.8							
4.9	Cancer 62day : Urgent RTT inc ITP transfers	85		78.3	73.5				64.7	80.5	81.6	73.5	76.5							
4.10	TIA: High Risk treatment within 24 hrs	62.5		66.4	63.3				51.3	70.8	83.9	68.0	63.3							
4.11	TIA: Low Risk treatment within 7 days from 1st contact	85		83.9	88.9				91.9	89.1	80.4	66.7	88.9							
4.12	4 hrs direct to Stroke Unit	90		81.9	91.0				71.2	85.0	84.8	77.8	91.0							
4.13	90% of time on the Stroke Unit	80		87.4	91.0				91.2	93.7	88.6	74.3	91.0							
4.14	60 minutes to scan	90		94.0	89.5				96.0	96.7	100.0	91.1	89.5							
4.15	Thrombolysed within 3 hrs	12		4.2	3.3				3.2	5.5	4.6	4.6	3.3							

5 - CARING

ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
5.1	Inpatient FFT % of patients would recommend	95		96.0	96.0				96.0	96.0	96.0	96.0	96.0							
5.2	FFT Response Rate %	40		44.0	44.0				42	39.0	42.0	48.0	44.0							
5.3	Friends & Family Recommend Place of Care	77		79.2	79.2				69.3			79.2								
5.4	Complaints - % received telephone call	85		97.2	99				97	92	100	98	99							
5.5	% of Complaints concluded within agreed timeframe	75		37.6	34				40	33	34	47	34							
5.6	GP Enquiries Reponse Rate	95		69.9	69.9				75.4386	78.6885	71.1628	71.7314	69.914							

6 - WELL-LED

ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
6.1	Continuity of Services Risk Rating	3		1					1	1	1	1	2							
6.2	Risk register	1		3																
6.3	CQC Outcomes	1		2																
6.4	NHSI Governance Risk Rating	4		2					2	2	2	2	2							
6.5	Friends & Family Recommend Place of Work	62		60.6	60.6				48.56			60.64								
6.6	Vacancy Rate %	10		13.2	13.2				13.4	13.2	13.7	13.1	13.2							
6.7	Vacancy rate (Baseline)	3.8		9.0	9.0				9.5	9.4	9.9	9.3	9.0							
6.8	Bank Staff Usage	9		4.5	4.5				4.2	4.6	4.67	4.6	4.5							
6.9	Agency Staff Usage	7		11.9	11.9				11	10.9	10.5	11.6	11.9							
6.10	Sickness %	3.5		3.6	3.6				3.60	3.61	3.65	3.61	3.61							
6.11	Substantive Staff Turnover	11.0		12.5	12.5				12.9	12.7	12.9	12.8	12.5							
6.12	Appraisal Rate	90.0		81.3	81.3				79.4	79.1	79.1	79.8	81.3							

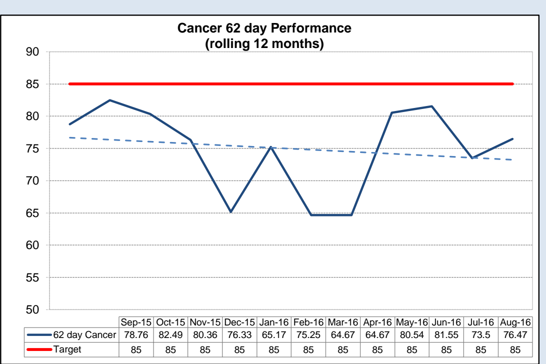
7 - FINANCIAL PERFORMANCE

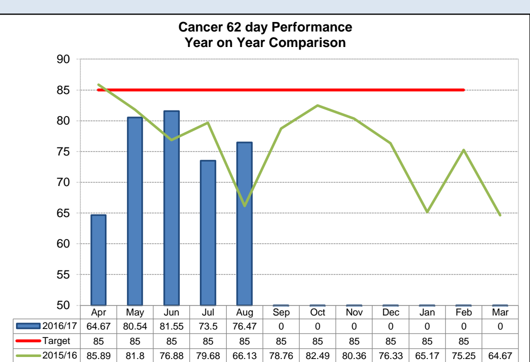
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
7.1	Pay Spend	100		102.5	102.5				100.4	99.9	100.64	100.59	102.47							
7.2	Net surplus	100		105.3	108.0				102	103	109.3	104.9	108							
7.3	Capital Plan Trajectory	90		32	33.5				88	72	22	29	33.5							
7.4	CIP Plan delivered	100		107.0	99.0				97	131	124	100	99							
7.5	Capital Cost Absorption	3.5		3.5	3.5				3.5	3.5	3.5	3.5	3.5							
7.6	Cash Plan	90		145.4	145.4				577.0	144.1	164.0	144.6	145.4							
7.7	Capital Servicing Capacity	3		1.0	1.0				1	1	1	1	1							
7.8	Liquidity Ratio (days)	3		2.0	2.0				1	1	1	1	2							

8 - SUSTAINABILITY

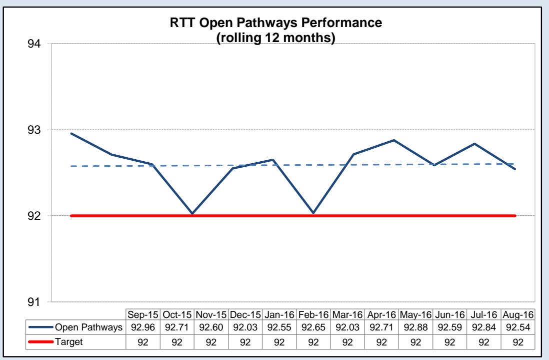
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
8.1	GP referrals Received - 2WW			3719	908				641	650	743	777	908							
8.2	GP referrals Received - non 2WW			42010	7900				8882	8263	8681	8284	7900							
8.3	A&E Attendances	147144	24567	24692	13094				11598	13094										
8.4	Elective Spells (PBR)	37060	6034	6285	3102				3183	3102										
8.5	NonElective Spells	46703	7575	7382	3847				3535	3847										
8.6	OP Attendances/Procs (Total)	471770	76758	80716	40500				40216	40500										
8.7	Outpatient DNA Rate	8		8.2	7.97				8.44	8.27	8.25	8.02	7.97							
8.8	Theatre Utilisation	Method of Data Collection and Definition to be confirmed - Reporting from Month 6																		

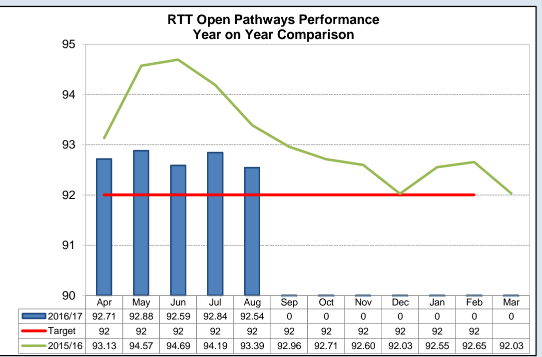
Trends in Key Performance Areas



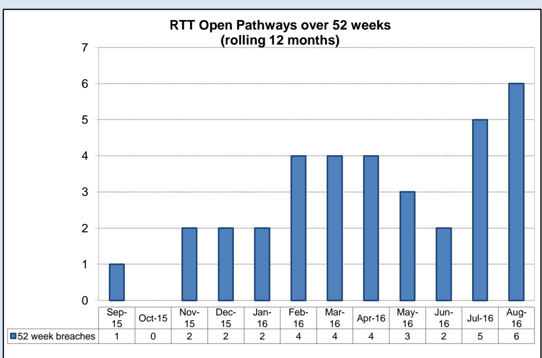


The Cancer performance figures are the latest validated position available so data shown in August is the validated July position. Over the rolling 12 months up to August 2016 the 62 day Cancer Performance is on a general downward but has seen an increase in performance in August 2016 compared to the previous month. Year on year comparison shows that the performance August 2016 is above that for the same month last year.

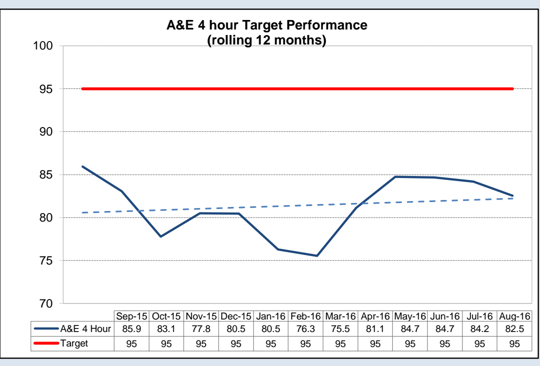


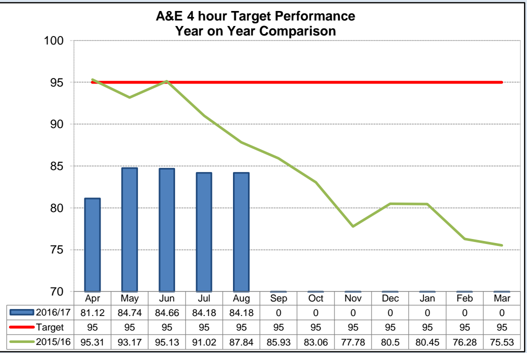


Over the rolling 12 months up to August 2016 the RTT Open Pathways Performance has remained constant at approximately 92.5% and has remained above the national target level of 92% for the period. A year on year comparison shows that the performance in 2016/17 is below the reported levels of 2015/16 for the first 5 months of the year. With an increasing number of administrative errors and issues being uncovered and rectified in time to support the migration to Lorenzo it should be expected that RTT performance may reduced below the national standard.



The key issue driving the level of patients waiting over 52 weeks is incorrectly stopped clocks. In August a process commenced to validate all historic outpatient clock stops. This initiative will result in an increased risk of 52 week waiters being uncovered and is the reason for the increase in Augusts numbers.





Over the rolling 12 months up to August 2016 performance against the A&E 4 hour target is on a general upward trend. Year on year comparison shows that whilst performance in 2016/17 is significantly below the same period in 2015/16 the performance is not declining in a similar way but holding steady at approximately 85%.

Agenda Item: 9.1

TRUST BOARD MEETING (PART I) – 28 SEPTEMBER 2016

MORTALITY REPORT

PURPOSE	To provide Trust Board with an update on mortality
PREVIOUSLY CONSIDERED BY	RAQC, Elements considered by the Trust Mortality Group (Clinical Governance Committee)
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☑ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	As identified in the report
Healthcare/ National Policy (includes CQC/Monitor)	CQC Compliance
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

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

DIRECTOR:	Medical Director
PRESENTED BY:	Medical Director
AUTHOR:	Clinical Improvement Lead / Medical Director
DATE:	September 2016

We put our patients first We work as a team We value everybody We are open and honest
We strive for excellence and continuous improvement

* tick applicable box

1. BACKGROUND

Reducing mortality is one of the Trust's key objectives for 2014 to 2016. This bimonthly report summarises the results of mortality improvement work and the regular monitoring of mortality rates that are a continual ongoing process throughout the Trust.

Schemes to reduce mortality form an important part of the *Improving Patient Outcomes Strategy 2015-2018* and link closely with other clinical quality initiatives such as Clinical Effectiveness, Patient Safety and Patient Experience all of which are regularly reported to the Risk and Quality Committee (RAQC).

Further information on the key metrics, developments and current risks summarised on this page can be found in Appendix 1. The full mortality report with a more in-depth study of mortality issues follows in Appendices 1-3.

2. KEY METRICS

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

Metric	Result
Crude mortality	Crude mortality is 1.66% for the 12 month period to July 2016 compared to 1.71% for the latest 3 years.
HSMR **(data period June2015 –May2016)**	HSMR for the 12 month period is **94.70** and is statistically **'lower than expected'**
SHMI **(data period Apr 2015- Mar 2016)**	SHMI for the 12 month period is **106.2** - **'as expected band 2'**
HSMR – Peer comparison	E&NH is one of 8 (out of 17) Trusts within the East of England Peer group with a '**lower than expected**' HSMR

3. DEVELOPMENTS

- Continued improvement in SHMI within 'as expected band'
- Well-functioning 7-day service in Respiratory medicine with Acute Chest Team shortlisted for "respiratory service category" in the Nursing Times Awards
- Continued progress in the development of Stroke service despite increased activity
- National Mortality Review Methodology: RCP in the process of finalising documentation prior to the pilot phase testing.

4. CURRENT RISKS

Table 2 below summaries key risks identified:

Risks	Report ref (Mitigation)
Potential destabilisation of Stroke service by situation in surrounding Trusts	1.6.3
Sepsis – Significant changes to NICE Guidelines 51	1.6.4.2
Gastroenterology – operational issues	1.6.5
Continuing IT issues preventing the launch of the national AKI algorithm	1.6.6
Elective AAA mortality still remains relatively high as Vascular review commences	1.7.1
Slow progress with 7 day service	1.8.2
IT issues with Mortality Audit Tool	1.8.4
Coding capability	1.9

Appendix 1

MORTALITY DETAILED UPDATE REPORT FEBRUARY 2016

1.1 Introduction

Reducing mortality is one of the Trust's key objectives for 2014 to 2016. This bi-monthly report details the results of mortality improvement work and the regular monitoring of mortality rates that are a continual ongoing process throughout the Trust.

Schemes to reduce mortality form an important part of the *Improving Patient Outcomes Strategy 2015-2018* (IPOS) and link closely with other clinical quality initiatives such as Clinical Effectiveness, Patient Safety and Patient Experience all of which are regularly reported to the Risk and Quality Committee (RAQC). Patient safety indicators, as well as other Trust wide and clinical pathway mortality data, are included on the Mortality Improvement dashboard and can be seen in Appendix 3.

The Trust also works in tandem with the TDA and CCG on specific mortality reduction initiatives via the Mortality Review Group. This forum provides our external partners with the opportunity to discuss and review all the Trust's activities aimed at reducing mortality and to make requests and recommendations as appropriate.

1.2 Mortality indicators

There are three main types of mortality indicator. Crude mortality is a simple analysis of the percentage of patients who died in hospital against the total number of discharges from hospital and makes no adjustment for patient acuity. The Hospital Standardised Mortality Ratio (HSMR) is a logistical regression calculation developed by Dr Foster to measure in-hospital mortality for 80% of the most common diagnosis categories resulting in patient deaths. It includes case-mix adjustment for a range of factors including patient age and patient acuity and for the delivery of palliative care.

The Standardised Hospital Mortality Index (SHMI) is also based on a logistical regression model and measures hospital mortality outcomes for all diagnosis groups along with deaths in the community up to 30 days after discharge. This measure is published by HSCIC. In additional to the different scope of this measure, the case-mix adjustment varies from HSMR in a number of ways with a key difference being that SHMI does not make an adjustment for palliative care.

Crude mortality is available within one day following the end of the month. HSMR is 3 months in arrears and SHMI 7-9 months in arrears.

1.3 Crude Mortality

Crude mortality is most useful in monitoring the performance of a defined clinical unit where the case-mix is expected to remain stable over time. It is of little use for comparing the performance of clinical units with differing case-mix where mortality varies thus a hospital with complex medical services or a hospice will have a higher crude mortality that another hospital with a high proportion of elective or ambulatory services.

Nationally the average crude inpatient mortality (derived from Dr Foster mortality) comparator is 2.33% compared to 2.36% within ENHT. This data is driven by

payment by result (PbR) rules which do not include all the activity that the Trust has undertaken. Basic PbR exclusions include some Cardiology procedures and Fractures as these treatments are on bulk contract.

Figure 1 shows the Trust crude mortality rate for the last three years along with the long-term mean over this period. This local crude mortality includes all the activity that happened at the Trust and a simple calculation against the number of spells. Table 1 provides the data for deaths, discharges and the crude mortality rate for the rolling 12 month period together with the current financial year 'YTD' position. The 3 year average rate for crude mortality shown in figure 1 is 1.71% and 1.66% for the latest rolling year August 2015 to July 2016.

Figure 1: Trust Crude Mortality Rate August 2013 to 2016

ENHT Crude Mortality Rate

Source: Acumen Deaths in Hospital Report; RICK Data Warehouse

Table 1: Trust Crude Mortality Aug 2015 to Jul 2016

	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	YTD (2016-17)
Discharges	8547	8007	8319	8547	7662	8040	8496	8250	7882	8023	8287	8388	8391	**33089**
Deaths	122	126	115	122	130	109	121	139	145	150	158	115	125	**548**
Crude Mortality	1.43%	1.57%	1.38%	1.43%	1.70%	1.36%	1.42%	1.68%	1.84%	1.87%	1.91%	1.37%	1.49%	**1.66%**

Note: the volume of discharges data has been updated back to April 2014 to reflect data quality improvement actions to accurately reflect the true level of activity in CDU

Within these figures there can be considerable variation especially at site level and when there are changes in clinical pathways. Increased management of patients via ambulatory routes such as "hot' clinics may result in rising crude mortality.

There is normally strong seasonal variation in crude mortality across England but this year it appears that the usual sharp winter spike was replaced by a far less pronounced but protracted elevated trajectory which did not settle until June.

1.4 Hospital Standardised Mortality Ratio (HSMR)

The HSMR is a powerful measure of performance compared to crude mortality as it effectively benchmarks the performance of a trust against all English acute non-specialist hospital Trusts. It is at its most effective as a comparator when viewed at Trust level and for a twelve month rolling period to reduce the seasonal variation.

The Trust's HSMR position for the last twelve months to May 2016 was **94.70**. ENHT is currently one of 8 (out of 17) Trusts within the East of England Peer Group with a statistically "lower than expected" HSMR. The Trust's position relative to all Trusts in England can be viewed in Appendix 2.

1.4.1 HSMR Performance

One of the strengths of the HSMR model is the ability to review the calculations for individual months and for units of analysis within a Trust. HSMR at the Trust is reviewed at both Trust level and for each Division against appropriate thresholds and reported on the Trust Board Performance Report showing rolling 12 month performance. Table 2 shows Trust and Divisional monthly performance RAG rated 2015/6 targets. Surgical HSMR has steadily improved over the past 6 months.

Table 2: Monthly Trust and Divisional HSMR June 2015 to May 2016

	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	12M Rolling
Trust	92.65	88.23	110.83	85.24	88.33	101.96	95.97	92.89	87.60	96.41	91.49	105.24	94.70
Medicine	93.24	92.18	112.39	86.64	87.89	98.14	97.70	87.25	88.35	101.56	92.24	115.71	96.05
Surgery	82.29	102.06	128.14	108.43	76.12	123.80	95.71	109.90	91.59	69.02	97.65	91.72	97.60
Women& Children	145.63	0.00	124.59	257.95	131.32	101.40	0.00	0.00	0.00	224.07	105.69	0.00	113.41
Cancer	92.89	55.57	74.12	43.69	105.81	101.44	84.97	125.30	81.80	80.95	84.01	65.83	80.54

Note: HSMR calculated using Feb 2016 Benchmark

1.4.2 HSMR Trends

The monthly Trust-level HSMR is shown in Figure 2.

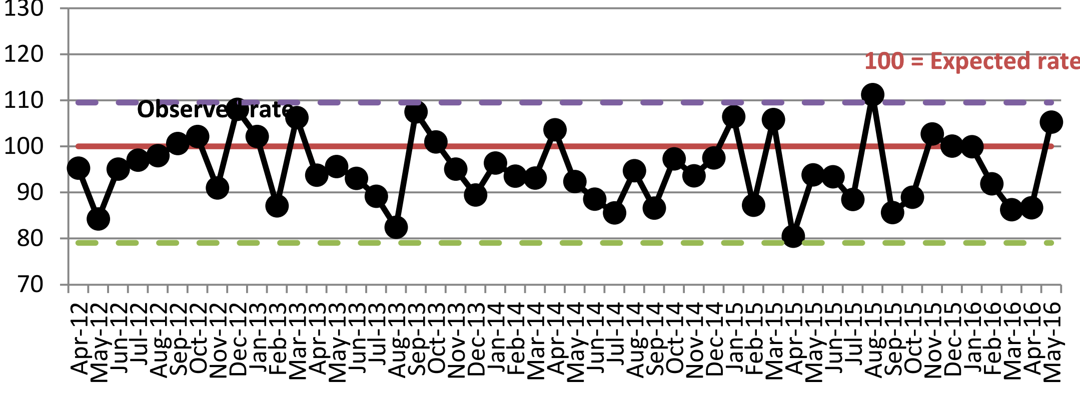
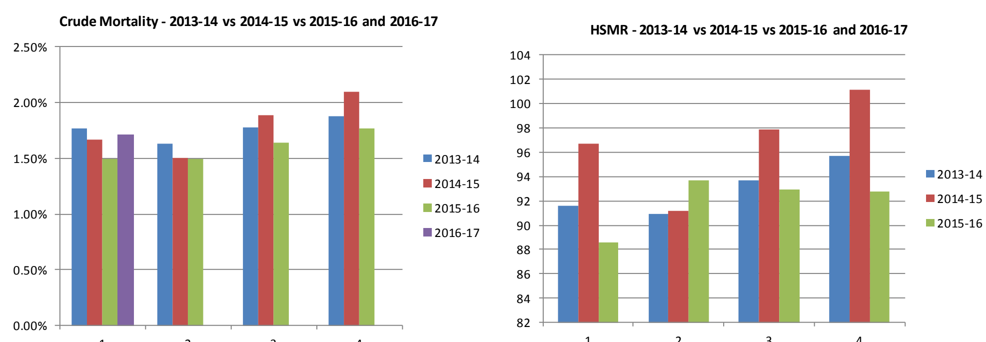


Figure 2: HSMR Trend by Month

The observed number of deaths within the risk model for HSMR is the greatest factor determining the overall score for an organisation. The relationship between the levels of crude mortality and HSMR can be seen in figure 3 below. Crude mortality can be used as a useful predictor of coming HSMR performance.

Figure 3: Crude Mortality and HSMR



1.4.3 HSMR Outliers

With regard to HSMR for the rolling year, table 3 below shows the one diagnostic group (Other Liver Diseases) which is currently alerting at the 95% confidence level for relative risk where 6 or more deaths are observed.

Table 3: HSMR Negative Outlier June 2015 to May 2016

	Relative Risk	Observed Deaths	Expected Deaths	“Excess” Deaths
Other Liver Diseases	173	19	11.0	8

Source: Dr Foster Intelligence Quality Investigator

At the request of the Trust’s Mortality Surveillance Group the Head of Clinical coding, an NHS Classifications Service approved clinical coding auditor, conducted an audit of cases of death within each group to ascertain whether or not the reported excess deaths had been appropriately allocated to the diagnostic basket. This audit was conducted following national standards for clinical coding and clinical coding audit.

The audit found that 7 out of the 17 cases reviewed had an incorrect primary diagnosis code. The conclusion was that it was unlikely that the Trust should have been considered an outlier and that the results suggest that the Trust is actually performing well in this area. Training is being put in place to address.

1.4.4 CQC CUSUM Alerts

There have been no new CQC CUSUM alerts since October 2013.

1.4.5 Key Quality Measures

It is important to triangulate mortality data with other quality measures to give a balanced perspective on quality of care provided by the Trust. Table 4 shows the index based on observed over expected values for HSMR, Length of Stay and Re-admission for the rolling year up to May 2016. In all cases the index is standardised at 100 where this value represents both the national average and values below 100

suggest the Trust is better than average. The RAG rating is provided to denote areas statistically better (or worse) than average.

Table 4: Key Quality Measures June 2015 – May 2016

	Trust Total	Elective	Non-Elective
HSMR	94.7	55.8	95.7
Length of Stay	87.5	66.6	91.9
Readmissions within 28 days	108.2	112.7	107.2

Source: Dr Foster Intelligence Quality Investigator

HSMR mortality continues to show a relatively good level of performance and Length of stay has remained consistently below the expected levels meaning we discharge patients sooner than expected based on our case mix. Since my last report the readmissions rate, while still elevated, has seen a marginal reduction for both elective and non-elective admissions.

A detailed audit of re-admissions in the Surgical, Womens & Children's and Cancer Divisions for PBR has shown 18 (19%) of the total cases audited were identified as being avoidable re-admissions although one third of these were considered to be unrelated to the initial admission. The learning points were primarily for the Surgical Division and will be shared.

1.5. Standardised Hospital Mortality Index (SHMI)

SHMI alongside HSMR can be a powerful benchmarking tool. The methodological differences between these two models do provide some challenges for the Trust as the reported performance is significantly divergent with HSMR being generally positive and SHMI more likely to suggest areas for further work. The discrepancy is partly accounted for by 7-day provision of palliative care services in the Trust and it is notable that the Lister has a significantly higher proportion of patients with end-stage respiratory and cardiac disease who are admitted to die in the Trust compared to the norm in England. In addition the Trust remains in a small minority of Trust's that include a hospice.

As anticipated the HSCIC overall SHMI for the period April 2015-March 2016 showed a marked fall and is now 106.2 and a substantial improvement in relative position. More detailed analysis of SHMI by diagnostic group for this period will be provided in the next report once Dr Foster mortality comparator has refreshed.

1.5.1 SHMI Mortality Triangulation

We use two approaches to identify areas for investigation into potential mortality problems: diagnosis groups with the highest number of deaths as small improvements in care could benefit a large number of patients; and diagnosis groups with high 'excess' deaths.

Detailed breakdown of SHMI by diagnostic group is available for the year ending December 2015. The five diagnoses resulting in the highest number of deaths during this period are Pneumonia, Acute Cerebrovascular Disease (which includes stroke), Urinary Tract Infections, Septicaemia and Acute and Unspecified Renal Failure. Significantly elevated pathways are denoted in red.

Table 5: SHMI Diagnosis Groups with highest death rate

Key Pathways	Spells	Observed Deaths	Expected Deaths	SHMI	SHMI Change	Latest HSMR	Crude Mortality
Pneumonia	1612	367	323.2	113.6	↓	102.4	17.1%
Acute cerebrovascular disease	672	145	116.9	124.1	↑	82.6	16.17%
Urinary tract infections	1683	101	101.5	99.5	↓	78.6	17.86%
Septicaemia	360	85	68.6	123.1	↑	103.9	3.09%
Acute & unspecified renal failure	393	79	69.3	114.0	↓	95.3	13.45%

Table 6 shows the five diagnoses with the highest number of "excess" deaths. Excess deaths are the actual number of deaths over the expected number for our population that have been calculated within the SHMI case-mix adjustment.

Table 6: SHMI Diagnosis Groups with highest excess

Key Pathways	Spells	SHMI Oct 14 – Sep 15	SHMI Jan 15 – Dec 15	SHMI Change	"Excess Deaths"
Pneumonia	1612	116.5	113.6	↓	44
Acute cerebrovascular disease	672	121.7	124.1	↑	28
Intestinal obstruction without hernia	227	194.7	181.2	↓	17
Acute myocardial infarction	606	125.6	137.4	↑	17
Septicaemia	360	118.5	123.1	↑	16

Measures in train to reduce deaths in these areas are explained in more detail in 1.6.

1.6 Specific Actions to Address High Mortality Conditions

1.6.1 Pneumonia, Acute Bronchitis & Chronic Obstructive Pulmonary Disease (COPD)

We continue to build on the many improvements implemented since 2012. Details of current initiatives and updates are provided below.

Royal College of Physicians Review: Progress continues on the joint actions agreed with the CCG following receipt of the final report from the RCP.

Telephone community consultations have now started and are a point of access for GPs to engage respiratory consultants regarding complex community cases. As take-up by GPs has remained slow the service continues to take calls from nurses, ICRS (Community Respiratory Team) and diverted GP referrals to ACT. Virtual Clinics/MDT are scheduled to commence in September.

The rollout of the community service continues but has encountered recruitment difficulty. The team continues to work with practices to highlight frequent attenders and to support early discharge from hospital where appropriate. The small project in the Stevenage area using technology to support patients at home continues.

1.6.2 Acute Chest Team (Post CQUIN)

While the CQUIN has now concluded the Acute Chest Team service continues with data collected for internal audit purposes as part of the ongoing assessment of the

Trust's respiratory service. Of note is that the service has been shortlisted for "respiratory service category" in the Nursing Times Awards.

There is a continuing objective to reduce both HSMR and SHMI mortality rates for the adult respiratory basket identified below, irrespective of which specialty team the patient was under.

Table 7: SHMI Respiratory Diagnosis Groups for CQUIN

CQUIN Pathways	HSMR 2014/15	HSMR Jun15 -May 16	SHMI Jan 14 – Dec 14	SHMI Jan 15- Dec 15
Respiratory basket total	105.8	102.90	126.9	111.70
Pneumonia (73)	102.1	102.42	112.8	113.56
Acute bronchitis (74)	113.0	113.38	164.4	123.5
COPD & Bronchiectasis (75)	125.0	96.55	160.3	117.53
Other upper respiratory Disease (subset of 82)	143.9	140.07	186.3	62.9
Other upper respiratory infections (subset of 82)	0	0		
Other lower respiratory disease (81)	72.1	92.15	80.6	92.12

Note 1: HSMR benchmark 14/15

Note 2: SHMI for the total Respiratory basket is a calculated figure based on the basket components

Note 3: Other upper respiratory disease & respiratory infections are combined in HSCIC preview data; HSMR benchmark Sep'14

There are continuing improvements being seen in Respiratory HSMR levels, notably in COPD. The full roll out of the Community based Respiratory Service should result in further improvement in SHMI..

1.6.2.1 Seven day Respiratory service

The Respiratory service, responsible for the care of patients with the most complex respiratory disorders, was commended as outstanding in the CQC Hospital Inspection report.

Since the establishment of the 7 day respiratory service we have struggled to recruit the full complement of substantive Consultants. There are 2 substantive posts currently advertised with a closing date of 2 October 2016. Interest has been good and we are hopeful that the 2 posts will be filled.

Table 8 below triangulates performance for the most severely ill respiratory patients who are admitted under the Respiratory team and compares it for the past 2 years. Whilst there has been an increase in the Respiratory HSMR (speciality of discharge), which may reflect the impact of admission prevention for less severe cases, there have been significant reductions in both the Length of Stay and Readmissions rate.

Table 8: Respiratory 7 Days Service Data

Respiratory (Speciality of discharge)	Jun14-May15	Jun15-May16
HSMR	120.4	129.8
LOS (HSMR basket)	154.8	130.5
Readmissions within 28 days	112.3	107.9

1.6.3 Acute Cerebrovascular Disease (Stroke)

The Stroke SHMI has been a cause for concern but HSMR is good at 83, a slight reduction since my last report, and actual deaths continues to reduce sharply despite an increase in activity of approximately 10%.

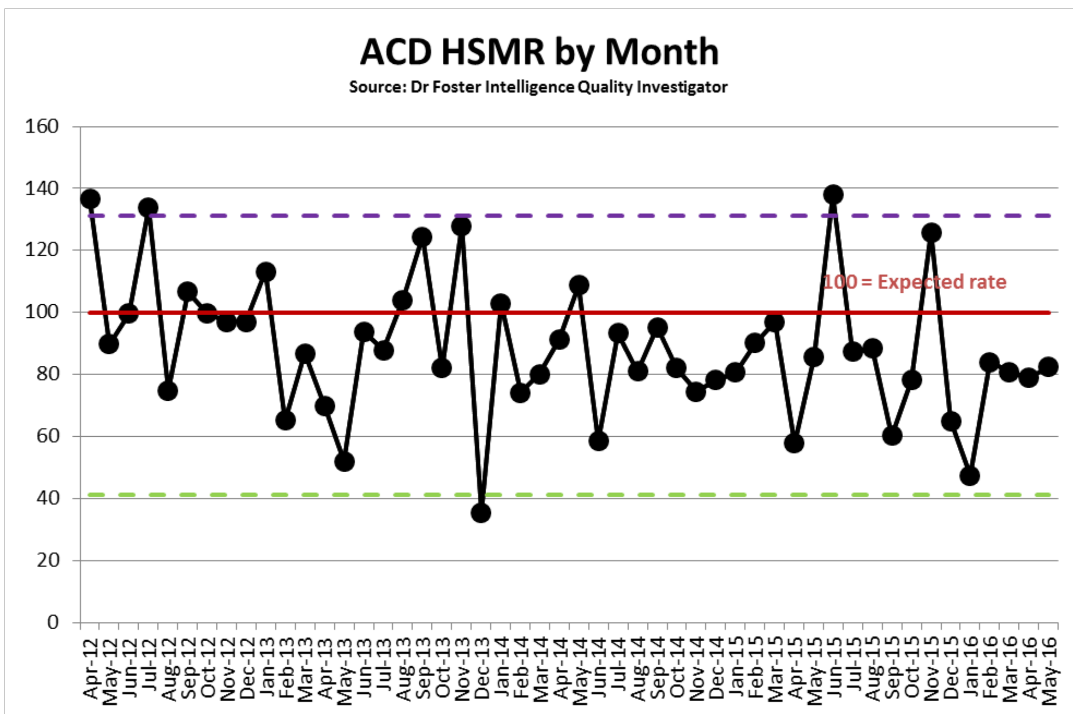


Figure 4: Acute Cerebrovascular Disease HSMR by Month

Recent reports to this Committee have outlined a variety of improvements that have taken place in Stroke care to improve outcomes for patients. We continue to embed these improvements and build on them. The following key points are of note:

- Improved performance for 4 hour metrics has been maintained despite the increased demand following the closure of PAH
- 7 day TIA service for high risk TIAs and review of new patients on HASU by consultants has been running successfully since June
- Successful appointment of a clinical Psychologist to the team who commenced in August
- Two new Consultants have been appointed to substantive posts
- The unit is working on the development of a Thrombectomy Service with CCGs and other centres
- The threatened closure of Bedford Acute Stroke service took place on 4 July which has led to further additional stroke activity at Lister.

1.6.4 Sepsis

1.6.4.1 Sepsis CQUIN

The targets embodied in the 2016/17 CQUIN are challenging.

In Q1 the target of screening ≥90% of all ED patients was met, with the Trust screening 90.3% of patients. However antibiotic delivery within 1 hour for ED and AMU was only 36% for Q1 which was primarily due to sepsis nurses being diverted to other clinical duties in ED. For this reason the sepsis team will be increased from two to three nurses.

72 hour antibiotic review has likewise been extremely challenging regarding patients who develop sepsis on the ward as in the absence of eObs there is no straightforward way of prospectively identifying patients when they have not been screened via ED. A process for identifying these patients has now been devised.

1.6.4.2 NICE Guideline 51

The most significant update regarding Sepsis relates to the release of NICE Guideline 51 "Sepsis: recognition, diagnosis and early management" at the beginning of July. This Guideline is significantly different from earlier guidance and as a result the additional markers incorporated within the BIMS sepsis section are no longer sufficient; screening tools are no longer fit for purpose and local guidance requires significant revision.

The Sepsis Group oversees all sepsis-related work within the Trust including the review and implementation of the above guidance and compliance with the CQUIN requirements. A sub-group met on 15th July to discuss the new Guidelines and agreed the following initial key actions:

- Immediate review of EPR/BIMS (this has been completed). An application to update BIMS has been submitted with completion expected in October)
- Request for involvement of paediatric, neonatal and maternity teams in a coordinated approach
- Delivery of an update of changes to CDs which took place on 4th August
- Draft plan for guideline revision, training programmes, awareness raising and documentation.

At its meeting on 5th August 2016 the Sepsis Group agreed a raft of further actions including:

- Review both the NICE and Sepsis Trust tools for adults, maternity and paediatrics; evaluate which tool/amalgamation of tools work best; make the necessary modifications
- Review and revise local and trust-wide guidance (inc. IV Fluid Therapy in Adults (CGSG 145); Managing Sepsis Policy (CP 177); Maternity 4.7 Management of Moderate and Severe Obstetric Sepsis)
- Revise the Terms of Reference.

1.6.5 Gastroenterology

In light of the concerns regarding elevated SHMI and HSMR the Gastro directorate has been reviewing elements of its service and has identified a number of current challenges facing the service which may impact on reported mortality:

- The mortality review process has highlighted that a significant number of deaths badged as Gastroenterology were actually attributable to general medical, elderly care and palliative /end of life patients. Newly clarified guidance regarding medical “ownership” should help to address this.
- Limited ‘out-of-hospital’ end of life provision was also identified as a contributory factor
- There have also been concerns regarding the feasibility of bed management to guide specialist GI patients to GI wards but it is anticipated that the situation will be alleviated to an extent when two 15 bedded Gastro wards are co-located.

Other initiatives to optimise patient care, including the recent introduction of the Liver Care Bundle which is covered in 1.8.3 and work continues towards achieving compliance following the NCEPOD Severe GI Haemorrhage national audit report 2014/15. From an Interventional Radiological (IR) point of view the Trust is non-compliant due to the lack of access to onsite interventional radiology 24/7 and the absence of network arrangements for interventional radiology out of hours. In this regard DEC recently approved the development of a full business case to establish an IR network centred at Lister.

1.6.6 Acute Kidney Injury

Following completion of the 2015/16 CQUIN an ongoing reporting regime has been agreed with the CCG. At the time of writing the Q1 report was being finalised ready for submission to the CCG.

Recent developments of note include:

- Trust AKI mortality is approximately 50% at one year for all AKI stages which is similar to large nationally reporting studies (although limited data available)
- Data analysis showed in-patient AKI incidence fell following the introduction of the AKI team in March (inpatient AKI incidence 7/1000 PCE/week vs 5.25/1000 PCE/week pre/post introduction)
- The team is working with the renal department to try to expand AKI service provision as currently the team’s impact is restricted due to limited staffing
- Collaborating with Diabetes Service to provide guidance to patients and primary care regarding the management of AKI in diabetic patients
- The team contribute to the national AKI patient safety cluster and have successfully submitted 3 posters for presentation at the American Society nephrology meeting, Chicago, Nov 2016
- The national AKI algorithm was launched into the Trust live ICE system by TPP but withdrawn almost immediately due to technical difficulties with loss of staging data provision. This is now 2 years late in delivery.

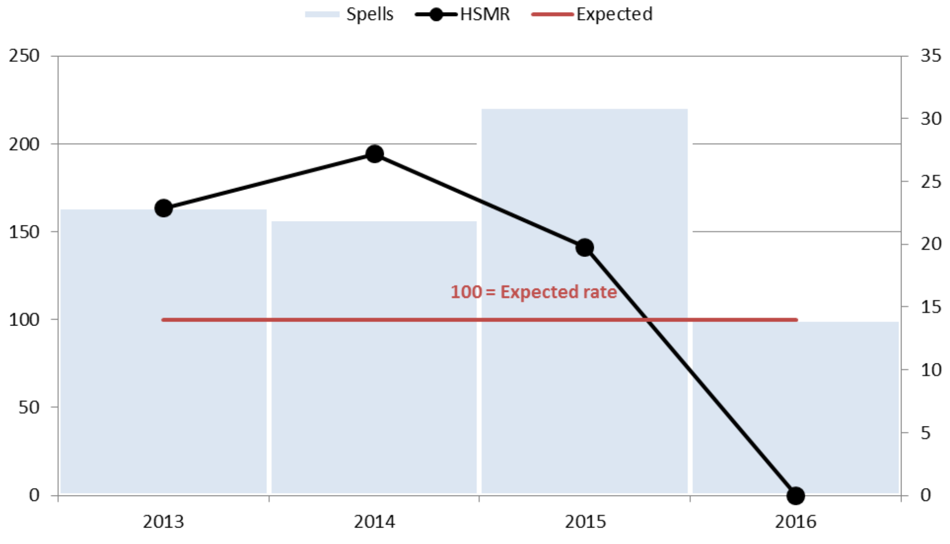
1.7 Update on Strategically Important Pathways

1.7.1 Elective Abdominal Aortic Aneurysm Repair (AAA)

The future of vascular surgery at the Trust remains uncertain. This is set against a backdrop of historical mortality concerns at the Lister Hospital following elective AAA surgery. The chart below shows the annual relative risk trend for elective AAA

procedures along with the total number of elective operations carried out (on the right). The relatively small numbers involved create more uncertainty in the indicative accuracy of the HSMR value and the reported value is not statistically significant.

Figure 5: Elective AAA Repair by Year



The key points regarding current activity remain largely unchanged since my June report:

- A decision is still awaited following the regional review of Vascular Surgery in the East of England & Midlands which commenced earlier in the year.
- Following the presentation made to the Executive Board on 19 May regarding collaboration with PAH discussions have remained ongoing

1.7.2 Deteriorating Patient Plan

Since February the Deteriorating Patient plan (DPP) working group has been incorporated into the Patient Safety Committee. Following publication of the results of the unexpected admissions to critical care audit the 2016/17 DPP action plan was discussed at the Patient Safety Committee in August.

Key points covered were as follows:

- Progress is on track for implementation of the eObs system and in the roll-out of education to support end of life care
- The transfer checklist has been introduced into the Emergency Department and acute assessment units
- The processes for managing urgent transfers from MVCC has been reviewed and confirmed as robust. Routine assurance monitoring has been established
- Consultant ownership has been clarified within the Medicine Division so that it is clear who is responsible for the patients on specific wards; and shared care principles put in place for patients whose care requirements straddle more than one team

- NHS Improvement has released national guidance for implementation by end January 2017. This guidance is being reviewed to ensure all aspects are captured within the DPP plan.

Following the June DNACPR audit while the results showed some improvements the documentation of the content of discussions with the patient remains an area of concern. A plan is being developed to address the issues identified, which is due for discussion at the next Resuscitation Committee on 18 September.

DNACPR and treatment escalation are currently being studied by Palliative Care both as part of the CQC development plan and also as part of the “Building on the Best - Shared decision making” work stream. If the national pilot of ReSPECT is a success it is hoped we will aim to roll it out across the Trust.

1.8 Other Trust-wide reducing mortality initiatives

1.8.1 Improving Outcome Strategy 2015-18

The Improving Patient Outcomes (IPO) Strategy 2015-18 combines a strategy for clinical effectiveness and patient safety has now entered Year 2.

A full End of Year report was provided to the Risk and Quality Committee for consideration in June. The report evidenced numerous areas of progress in Improving Outcomes in 2015/16 with a majority of schemes being achieved. Where Q4 objectives were not fully achieved these have been carried over for implementation in 2016/17 unless there are valid reasons why this should not occur. Objectives for 2016/17 have been refreshed to reflect progress over the first year of the strategy and any shifts in focus. These were presented to the Clinical Governance Strategy Committee in July and subsequently finalised.

1.8.2 Seven Day Working

ENHT is currently waiting for confirmation that it is in the tranche of trusts that are aiming to achieve compliance against the four prioritised standards by the end of March 2018. The four prioritised standards are:

- Standard 2: Time to Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant-directed Interventions
- Standard 8: On-going Review.

The next national survey of seven day services assessed against these standards is about to commence. Approximately 180 patient notes from emergency admissions will be audited to provide an update on progress against these criteria. There are a new set of questions in this survey that are aimed at both assessing the NEWS assessments and assessing consultant’s views on the availability of diagnostics. The survey is due to finish at the end of September with publication of the data a month later.

As already alluded to in 1.6.5 above an outline strategy that supports the development of a seven day service in Interventional Radiology has been drafted.

1.8.3 Care Bundles

Care Bundles either standalone or as part of an Integrated Care plan are now in place for the following diagnostic groups

- Pneumonia
- COPD
- Congestive cardiac failure
- Stroke
- Acute MI
- Decompensated cirrhosis

The newest care bundle is that for Decompensated Cirrhosis where the Trust has adopted the tool developed by the British Society of Gastroenterology and the British Association for the Study of the Liver. Decompensated cirrhosis is a medical emergency with a high mortality rate. The care bundle comprises a practical, evidence-based guideline designed to be used from the point of admission (within 6 hours), including a checklist of important aspects of Chronic Liver Disease management and related clinical advice.

The care bundle was introduced at the beginning of August and is now live in acute medicine and AMU. Over the ensuing weeks the bundle was promoted at morning report, SHO teaching sessions and other appropriate meetings in order to highlight its presence and encourage admitting doctors to use it.

In order to provide a benchmark, a retrospective study of the care of patients admitted acutely with decompensated cirrhosis is now scheduled. A prospective study will then be used to evaluate the bundle's use and to compare outcomes with the original retrospective data.

1.8.4 Mortality Review Process

We now have 29 trained mortality reviewers in place taken from across medical and surgical specialties. By the end of August 75% of total recorded deaths from 1 April 2016 to 31 July had been reviewed and the trajectory has risen steadily with changes to the process since April.

While excellent progress has been made to date our target of achieving a 95% completion rate is extremely challenging given the multitude of pressures on consultant time.

Areas of concern (ACONs) are forwarded to the Directorate RHDs for discussion and where relevant action/escalation via the Clinical Governance Strategy Committee.

As previously reported recent work to the "areas of concern" (ACON) process identified a number of IT anomalies. Due to the fact that a number of these reporting issues have remained outstanding for nearly 12 months, reportedly due to IT staffing issues, and has been raised through Datix risk. The team continue to press for resolution.

1.8.4.1 National Standardised Mortality Review Methodology

The national standardised mortality review methodology and training, which is being rolled out to all NHS trusts in England has been delayed. It was originally anticipated a pilot expected to start in April 2016. The Royal College of Physicians has been chosen to deliver the national Mortality Case Record Review Programme for the next 3 years. It is understood that RCP is in the process of finalising documentation prior to the pilot phase testing.

This pioneering programme aims to develop and implement a standardised way of reviewing the case records of adults who have died in acute hospitals across England and Scotland. Its main aim is to improve understanding and learning about problems in care that may have contributed to a patient's death.

1.9 Coding

As previously reported we are aware that the Trust faces significant long standing issues in the area of Coding. The new Head of Coding is due to start on the 19th September.

In the interim the following activities are of note:

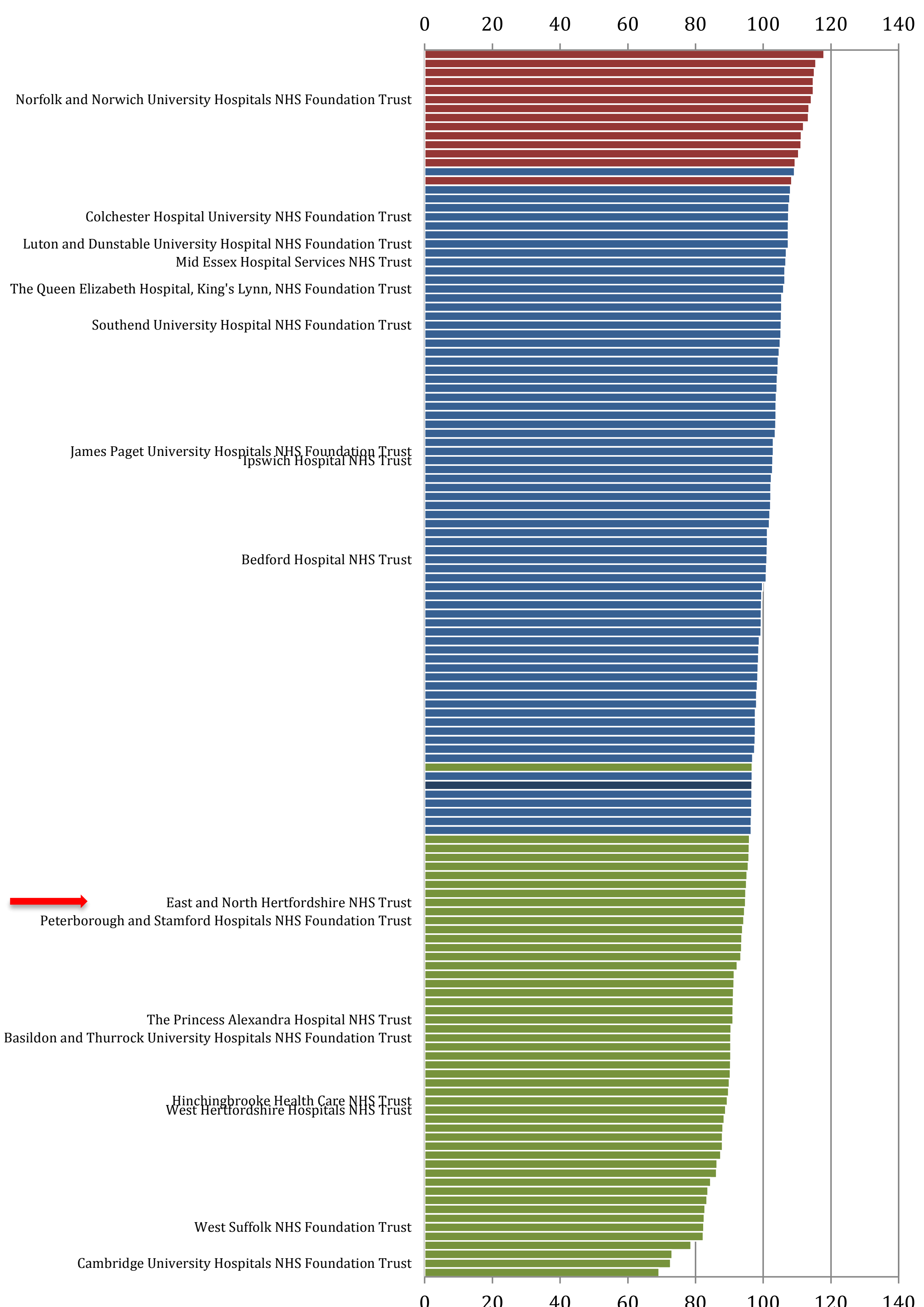
- Training is on-going across the team, with training on Orthopaedics and ERCP's completed and refresher courses scheduled for September and October
- Two Band 7 Divisional Leads have been recruited and commenced in post in August. Unfortunately recruitment was unsuccessful for the remaining two posts which were due to be re-advertised week commencing 5 September.
- 7 Band 3 Trainee posts have also due to be advertised week commencing 5 September.

1.10 Summary of Key Mortality Issues

- Crude mortality is 1.66% for the latest rolling year
- Overall HSMR performance is good and the Trust's overall position for the latest rolling year is 8th out of 17 trusts in EOE
- SHMI has reduced to 106.2 with a marked improvement in the Trust's relative position
- Numerous mortality improvement initiatives as detailed in the *Improving Outcome Strategy* 2015-18 are in train
- The mortality review process has been refreshed and good progress made to achieve 95% target completion rate for year end.
- Further information is anticipated from RCP following its appointment to lead the National Mortality Review Methodology regarding anticipated pilot phase testing
- Mortality monitoring is on-going with regular reporting to DEC, RAQC, Board, CCG and TDA
- Regular joint meetings are held with ENH CCG and TDA to improve mortality rates.

Appendix 2

England HSMR by Trust: Ranked and Banded Performance
Period: June 2015 to May 2016

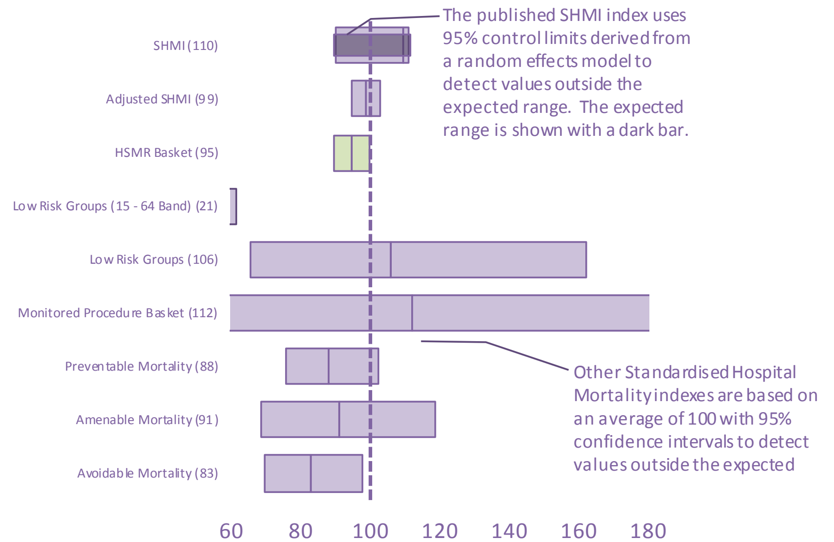


East and North Hertfordshire NHS Trust

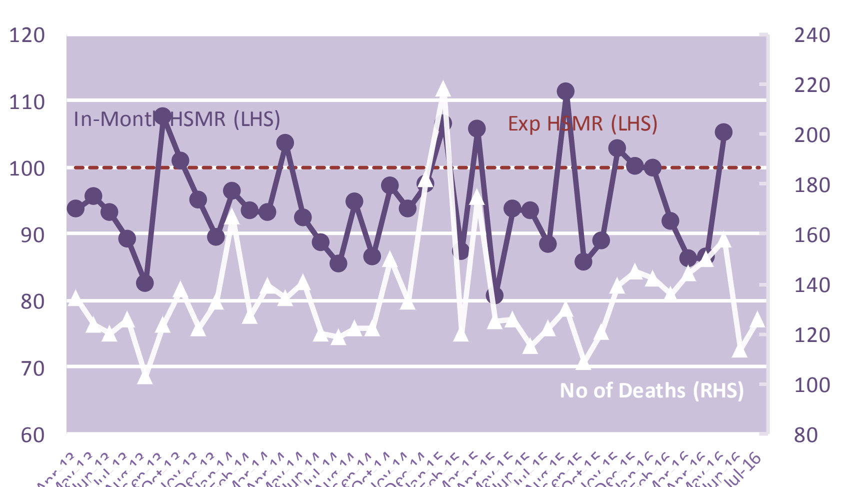
Mortality Improvement Plan August 2016 update

This dashboard reports on the twelve month rolling period ending May 2016, except SHMI data which is available for the rolling year ending December 2015.

The Trust will improve mortality and deliver HSMR and SHMI with the 'as expected' range or better



The HSMR Trend and expected rate shown against volume of deaths...



HSMR Performance

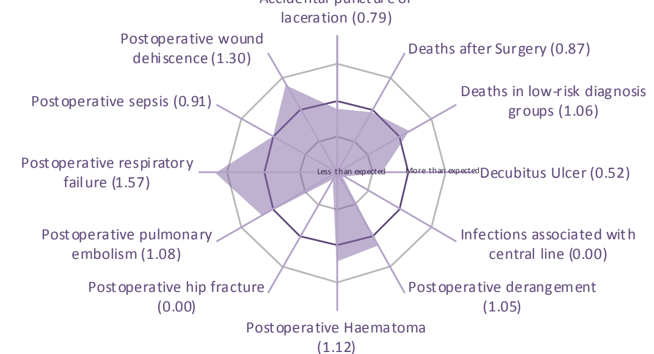
		Change	Performance
EoE Ranking Acute providers only	10/17	↑	☹

Leading Quality Indicators

Depth of Coding vs Upper Quartile June-16	118%	↑	☺
Charlson Index vs Upper Quartile July-16	108%	↓	☹
Palliative Care Coding vs National FYTD	180%	↑	
Deaths in Residual Code Group 12M	21	↓	☺
Crude Mortality Rate July-16	1.66%	↓	☺

Benchmark against Feb-16

Patient Safety Indicators



Data sources: Crude Mortality, Depth of Coding, Charlson Index - Acumen Data Warehouse; SHMI - HSCIC Clinical Indicator Portal; HSMR, Patient Safety Indicators, Adj. SHMI - Dr Foster Intelligence

Design and visualisation concepts: Informatics Department, July 2013

Selected Diagnosis HSMR Report August 2016 update

This dashboard reports on the twelve month rolling period ending May 2016, except SHMI data which are available for the rolling year ending December 2015 only

Expected Rate

Diagnosis Group (HSMR) : (SHMI)	In Hospital Deaths: Crude Rate	Palliative Care Rate
Acute bronchitis (113) : (124)	3%	29%
Acute cerebrovascular disease (83) : (124)	16%	49%
Acute myocardial infarction (101) : (137)	7%	15%
Acute and unspecified renal failure (95) : (114)	13%	36%
Congestive heart failure, nonhypertensive (79) : (105)	10%	41%
Fracture of neck of femur (hip) (77) : (108)	6%	19%
Pneumonia (102) : (114)	17%	31%
Septicemia (except in labour) (104) : (124)	18%	42%
Urinary tract infections (79) : (99)	3%	36%

Trend

40 60 80 100 120 140 160 180

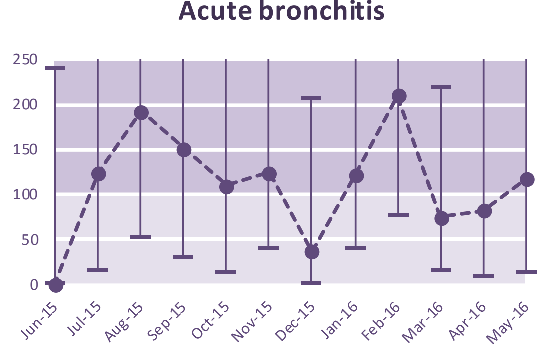
Data sources: Crude Mortality, HSMR - Dr Foster Intelligence; SHMI - HSCIC Clinical Indicator Portal

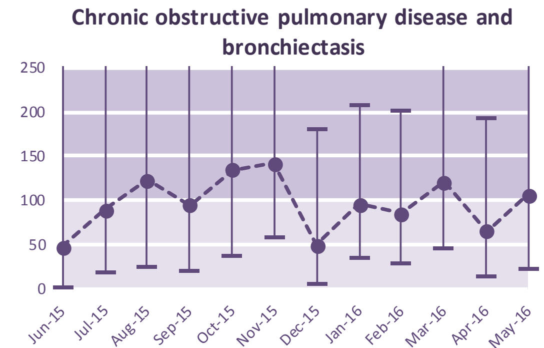
Design and visualisation concepts: Informatics Department, July 2013

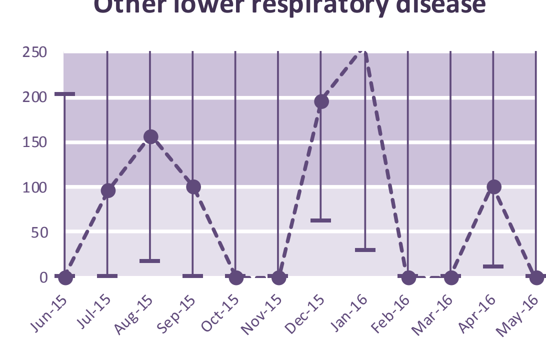
East and North Hertfordshire NHS Trust

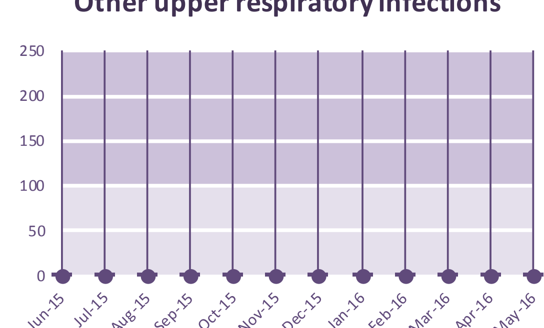
Respiratory CQUIN Trends August 2016 update

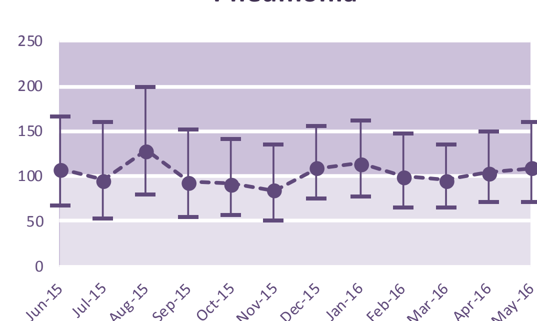
This report focuses on the twelve month rolling period ending May 2016 for in-month HSMR calculations for selected diagnostic groups.



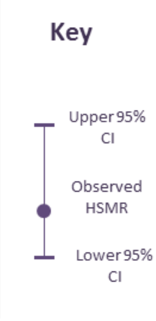








Key



Data sources: HSMR - Dr Foster Intelligence

Design and visualisation concepts: Informatics Department, November 2013

Selected Diagnosis SHMI Report August 2016 update

This report focuses on the twelve month rolling period ending December 2015 for diagnostic groups with the highest excess volume of deaths

Diagnosis	Spells	Deaths "Excess"	Deaths Crude Rate	Deaths Post Discharge
Pneumonia (114)	1,612	44	23%	19%
Acute cerebrovascular disease (124)	672	28	22%	18%
Intestinal obstruction without hernia (181)	227	17	17%	34%
Acute myocardial infarction (137)	606	17	10%	18%
Septicemia (except in labour) (124)	359	17	24%	24%
Acute bronchitis (124)	1,036	11	6%	42%
COPD and bronchiectasis (118)	890	11	8%	27%
Acute and unspecified renal failure (114)	393	10	20%	23%
Other liver diseases (114)	262	9	10%	44%

Expected Rate

80 100 120 140 160 180 200 220

Data sources: Crude Mortality, SHMI - HSCIC Clinical Indicator Portal; SHMI Diagnostic Group Confidence Intervals - Dr Foster Intelligence (not yet available)

Design and visualisation concepts:Informatics Department, August 2013

Agenda Item: 10.01

TRUST BOARD MEETING – 28 SEPTEMBER 2016

FINANCE AND PERFORMANCE COMMITTEE – 21 SEPTEMBER 2016
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Trust Board the report from the Finance and Performance Committee (FPC) meeting of 21 September 2016
PREVIOUSLY CONSIDERED BY	N/A
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key assurance committee reporting to the Board Financial risks as outlined in paper
Healthcare/National Policy (includes CQC/Monitor)	Potential risk to CQC outcomes Key statutory requirement under SFIs, SOs. Healthcare regulation, DH Operating Framework and other national performance standards
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**
ACTION REQUIRED *	For approval ☐ For decision ☐ For discussion ☑ For information ☐
DIRECTOR:	CHAIRMAN OF FPC
PRESENTED BY:	CHAIRMAN OF FPC
AUTHOR:	BOARD COMMITTEE SECRETARY/COMPANY SECRETARY
DATE:	21 SEPTEMBER 2016

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FINANCE AND PERFORMANCE COMMITTEE – 21 SEPTEMBER 2016

EXECUTIVE SUMMARY REPORT TO BOARD – 28 SEPTEMBER 2016

The following members were present: Julian Nicholls (Chair), Vijay Patel, Alison Bexfield (Trust Vice Chair),
Other directors in attendance: Nick Carver, Stephen Posey, Brian Steven, Bernie Bluhm, Tom Simons

DECISIONS MADE UNDER DELEGATED AUTHORITY:

The Finance and Performance Committee (FPC) made no decisions on behalf of the Trust under the authority delegated to it within its terms of reference:

OUTCOMES:

Floodlight Scorecard Month 5
The FPC received the floodlight scorecard for Month 5 indicating monthly and year-to-date performance, including RAG ratings against trajectories. Highlights included: HSMR continued its downward trend (one of the best performing Trusts in the region); an improvement in SHMI performance (the highest level it had ever been); lower mortality overall.

Finance Report Month 5
The FPC received the Month 5 finance report. The Trust delivered a £1.676m deficit in month creating a £146k favourable variance (£419k variance year-to-date). Key issues included:

- Clinical income was £1.327m higher than plan in month;
- Expenditure was £0.812m adverse to plan;
- Agency expenditure increased by £199k;
- 99% CIP delivery (greater levels of delivery assumed in the second half of the year);
- An adverse variance within Women and Children's income and expenditure;
- £1.454m cash balance at month end;
- Capital expenditure was below plan in month;
- Actions taken to improve the control environment.

The FPC referred a discussion on VAT to the Audit Committee.

The FPC noted key headlines relating to divisional income and expenditure analysis, the latest position relating to pay and non-pay expenditure, cash flow, the capital programme, debtors and creditors.

Appended to the finance report was an analysis of the Trust's performance in relation to its main contracts with CCG's and NHS England denoting an over-performance in both income and activity by 6.75% and 4.46% respectively.

TPP update
The FPC received a verbal update on the latest situation concerning TPP and requested early discussion on accounting treatment at Audit Committee. Further discussion would take place at Trust Board Part II.

2016/17 Year End Forecast
The FPC received an update on the year-end forecast including range of financial risks facing the Trust in 2016/17 noting further discussion would take place at Trust Board Part II.

Capital and Working Capital Loans
The FPC received an update on the current level of Capital Investment Loans, Working Capital Loans and anticipated further requirements noting the intention to seek further capital loan funding and the impact on future capital availability if surpluses could not be generated to meet loan repayments.

Performance Report Month 5
The FPC received the Month 5 performance report highlighting the Trust's position against 6 KPI's agreed with NHSI linked to funding recovery trajectories. Key headlines included:

- RTT continued to deliver the 18-week national standard and was forecasting to achieve trajectory in September;
- Implementation of a validation exercise to support delivery of the RTT 52-week wait patients;
- ED did not achieve the 4-hour standard in August but did achieve 84.66%, higher than the improvement trajectory; a clinical team from the Emergency Care Improvement Programme (ECIP) was due to visit ENHT on 30 September to review clinical pathways and assist recovery of this standard; the FPC requested further information on interventions recommended by ECIP;
- Implementation of a revised 62-day referral to treatment cancer action plan endorsed by commissioners and including clinical engagement;
- Delivery of the 4 hours direct admission to a stroke unit;
- Achievement of Diagnostics despite increased demand (99.6%).

Workforce Report Month 5
The FPC received the Month 5 Workforce Report concerning management of the workforce. Key areas of focus during the month were:

- Recruitment including significant challenges to the qualified nursing pipeline, an increase in turnover of band 5 nurses, a successful direct recruitment campaign with the Philippines and a positive visit to India (30 candidates successfully recruited);
- Temporary staffing reporting a reduction in month; agency unit costs continued to fall and a slight increase in agency medical staff largely relating to shortfalls in ED;
- Culture, specifically increased focus on development of leadership/coaching.

The FPC noted the Trust's Quarter 1 Staff, Friends and Family Test results were the best since the test commenced in April 2013 showing a marked improvement compared to the national acute Trust average moving the Trust out of the bottom quartile.

The FPC noted the overall improvement in the Trust's appraisal rate, requested the Executive investigate appraisal compliance of Senior Manager Pay and an update on statutory and mandatory training at its meeting in October.

OTHER MATTERS:

New Company Subsidiary Proposal
The FPC received a briefing on establishing a wholly owned subsidiary company to provide managed healthcare services to the Trust. The FPC authorised £25k spend on external advisors and supported the recommendation to obtain the necessary assurances from NHSI before proceeding to develop a business case for approval acknowledging learning would be taken from the Trust's first subsidiary, ENH Pharma. The FPC unanimously endorsed next steps to progress the new company subsidiary proposal.

Data Quality Metrics
The FPC received the latest update on data quality metrics noting average depth of coding was on an upward trajectory, outperforming the national average. The FPC was confident in the general direction of travel and supported more concise reporting of performance against

key performance indicators in future. The FPC requested details of Health Records metrics for October's meeting.

Procurement Update
The FPC received the quarterly update on procurement activities including progress against savings targets, Department of Health initiatives, tender waivers and key strategic tenders, noting these were aligned with recommendations of the Lord Carter Review published in February 2016. The FPC considered the revised Procurement Strategy and sought further assurance of costs management/effectiveness, materials management responsibility, efficiency of stock control/materials usage and value for money.

Lord Carter Efficiency Review
The FPC received an update on implementation of Carter Review recommendations, requested a deep dive into the four main priorities and a report back at FPC in October.

Lorenzo – Innovation Programme
The FPC received an update on progress towards delivery of the Lorenzo project noting the risks associated with the six-week delay in receipt of Lorenzo funding and a capital loan from the Department of Health. The FPC requested assurance of plans in place to mitigate risks associated with the delay and that future updates be included in the main agenda to understand risk profiles in greater depth. The FPC also requested assurance of governance of the electronic observations project.

Strategic Projects Review
The FPC noted the bi-monthly report on progress against each of the Trust's agreed strategic projects.

Julian Nicholls
Chairman

21 September 2016

Agenda Item: 10.1.1

TRUST BOARD – 28 SEPTEMBER 2016

FINANCE REPORT MONTH 5

PURPOSE	To set out the Trust's financial position for the period ending 31 August 2016
PREVIOUSLY CONSIDERED BY	**Finance and Performance Committee**
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Financial risks are described in the main report
Healthcare/ National Policy (includes CQC/Monitor)	Financial and contractual compliance with Department of Health policies including the Operating Framework for 2013/14. Monitor's Financial Risk Rating metrics are used within the report and appendices.
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

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

DIRECTOR:	Director of Finance
PRESENTED BY:	Director of Finance
AUTHOR:	Associate Director of Finance
DATE:	September 2016

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* tick applicable box

Financial Summary - August 2016

Key issue	Summary	Pages	In Month	YTD
I&E Summary	The Trust delivered a £1.676m deficit in month, against a planned deficit of £1.822m, creating a £146k favourable variance. This was after an additional £600k of contingency had been provided for in the month. Year to date there is a £7.430m deficit, which is £419k favourable to plan, after an additional year to date contingency provision of £2.7m.	*4*	Green	Green
Run rate analysis	There is a small deterioration to the normalised run rate in month, compared with the previous months, mainly due to lower income in the month, after adjusting for the refresh of prior months income. Month 5 income is expected to increase as part of the monthly refresh process.	*5*	Amber	Amber
Activity & Income	Clinical income was £1.327m higher than plan in the month (of which £0.4m related to prior months), and is £5.183m higher than plan year to date. There was over performance in month on non-electives, daycases, electives and outpatients, which was partially offset by under performances in Maternity and other non-PBR related areas including threshold adjustments.	*6*	Green	Green
Expenditure	Expenditure is £0.812m adverse to plan in month, before the impact of an increased contingency provision, though this reduces to £0.394m if the cumulative VAT adjustment for agency staff is excluded (see below). The expenditure run rate is consistent with the previous two months, excluding the impact of the VAT adjustment.	*7, 8, 10*	Amber	Amber
Agency Expenditure	This month the figures include £418k for an estimated year to date VAT adjustment relating to NHSP payments. Work is underway with external support to validate this and identify any options for the Trust to mitigate. As a result of this VAT adjustment, the year end forecast would be above plan of approximately £1.0m	*9*	Amber	Green
CIP plans	The CIP delivery in month was 99% (107% YTD). The next signifcant increase in planned delivery is month 7 (£0.585m higher than the month 5 target).	*11*	Amber	Green
Divisional Analysis	The Womens and Childrens Division continues to be the stand out division with a significant adverse position. Weekly meetings are being held with the Director of Finance and Division to identify any potential remedial actions to improve the position.	*12*		
Cash	There was a £1.454m cash balance at the end of the month, which is higher than the £1.0m required minimum cash balance, mainly due to timeliness of creditor payments	*13*	Green	Green
Capital	Capital expenditure is below plan in the month, as orders have been placed but goods and services have not yet been received	*14*	Green	Green
Balance sheet, Aged debtors & creditors		*15,16*		
Risks & Opportunities	The identified risks and opportunities have been incorporated into our year end forecast paper.			

Green	Better than plan
Amber	0-5% adverse to plan
Red	>10% adverse to plan

Financial Narrative - Key Issues - August 2016

The key issues identified for month 5 are as follow:

The month 5 position is positive with a £746k favourable variance from plan, prior to an additional £600k contingency. Year to date there is a £3,138k favourable variance, prior to an additional £2,720k contingency.

However, the Trust has significant risks to delivery of it's revised control target.

Revised Control Total
- The Trust has signed up on the 28th June 2016 to the revised control total of £8.65m, which would allow access to the £10.7m sustainability and transformation funding, subject to the conditions. To achieve the revised control total the Trust has assumed the removal of £2.0m readmissions penalties and £1.6m additional CCG funding. These have not yet been agreed with the CCG.

Sustainability and Transformation Funding
- The revised plan assumes that the STF funding of £10.7m funding will be received in full. The guidance confirms that 70% of the fund will be broadly based on quarterly performance against the NHSI agreed financial plan and 30% across the three main access targets. Operational pressures are likely to result in the Trust not receiving the full £10.7m STF funding.

To deliver the revised control total, the Trust needs to improve its control environment, identify new CIP schemes, reduce agency expenditure and mitigate emerging risks.

1) Improving Control environment
- The Trust has undertaken a number of actions in recent weeks to improve the control environment . These, along with some future initiatives, was detailed in a paper which was appended to the FPC action log.

2) CIP Forecast and Phasing
- The CIP programme is phased to deliver 31% CIPs in the first half of the year and 69% in the second half. The current CIP forecast indicates a £3.0m shortfall against the £15.5m target. Proposals to strengthen the CIP process, and to identify new CIP schemes, are currently being considered by the Executive team.

3) NHSP VAT reclaim
- It has been recently identified that the Trust has over-reclaimed VAT on invoices from NHSP going back to 2012. This issue is currently being pursued with Shared Business Services and our VAT advisors to validate the value of the overclaim and necessary actions to rectify this issue. The recurrent annual impact of this VAT error is approximately £1.0m, and so a year-to-date (£418k) provision has been included in the month 5 position.

- There is a further risk of approximately £2.0m relating to prior years, and the Trust will discuss with auditors and NHSI as to whether this can be actioned as a prior year adjustment. A separate paper will be presented to the audit committee In October 2016.

4**) Reducing Agency Expenditure**
It is a requirement of the STF funding that the Trust has a plan to reduce agency. A workforce and temporary staffing reduction plan has been developed and is appended to the action log. The Trust has been issued an agency ceiling target of £16.7m from NHSI, compared with the Trust's forecast of £28.6m. The VAT over reclaim will add £1.0m to the Trusts agency expenditure trajectory.

5) Income
The Trust is reporting a positive position on clinical income. However, the activity and income position do not appear to be aligned, particularly for non elective and elective inpatient income. A joint audit has been undertaken by the CCG and Trust regarding the reason for this, but the results are inconclusive as to whether the increase is due to a national move to ICD 10 version 5 or the grouper software. There is an affordability challenge to the CCG for this level of over performance.

6) tPP
The month five position does not relect any adverse impact relating to the unfolding position on tPP.

7) Mitigate Risks and Develop Opportunities
The Trust continues to experience a number of emerging risks and opportunities which will be presented separatly to the FPC committee.

8) Cash
Cash support from DH is expected of £8.6m to cover the 2016/17 forecast deficit plus an additional £4.2m to cover the additional 2015/16 deficit, although NHSI have indicated that a separate application will be required for the latter. The Trust is awaiting guidance from NHSI regarding the process and timing for accessing interim revenue support. The impact on the cash position of the scenarios in the year end forecast paper are being worked through.

Underlying deficit
The impact on the underlying deficit of the 2016/17 'most likely' forecast, is being worked through and will be presented at future meetings.

Development of FPC/Board Finance reporting
A schedule for future developments of the finance report has been produced. To date, further information regarding agency and waiting list expenditure has been included, as well as an improved debtors/creditors schedule.

A schedule of the income position by commissioner, and the income run rate analysis, will be included in a separate 'business report'.

Further developments of the FPC finance reporting include incorporating detail of the drivers behind agency expenditure, more detail on waiting list payments by specialty, SLR reporting and a schedule of contracting penalties and CQUIN funding.

Income and Expenditure Summary - August 2016

Performance against internal plan

	Current Month			Year to Date			Annual
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Income							
Income from NHS activities	29,938	31,265	1,327	150,626	155,809	5,183	362,740
Income from non NHS activities	537	464	(72)	2,570	2,040	(530)	6,328
Other operating income	4,181	4,150	(30)	20,704	20,700	(4)	52,564
Total Income	**34,656**	**35,880**	**1,224**	**173,901**	**178,550**	**4,649**	**421,632**
Expenditure							
Pay	(21,183)	(21,705)	(522)	(105,965)	(106,801)	(836)	(252,526)
Non-Pay	(13,191)	(13,517)	(326)	(66,299)	(67,399)	(1,100)	(154,853)
Unallocated Budgets	(668)	(631)	37	(2,304)	(2,220)	84	(5,665)
Total Expenditure	**(35,041)**	**(35,853)**	**(812)**	**(174,567)**	**(176,419)**	**(1,852)**	**(413,044)**
EBITDA	**(386)**	**26**	**412**	**(667)**	**2,130**	**2,797**	**8,588**
PDC Dividends payable	(194)	(194)	0	(972)	(972)	0	(2,333)
Depreciation	(691)	(358)	333	(3,454)	(3,121)	333	(8,290)
Investment Revenue	2	3	1	11	19	8	25
Finance Costs	(303)	(303)	0	(1,517)	(1,517)	(0)	(3,640)
NET SURPLUS / (DEFICIT) before contingency	**(1,572)**	**(826)**	**746**	**(6,599)**	**(3,460)**	**3,139**	**(5,650)**
Contingency	**(250)**	**(850)**	**(600)**	**(1,250)**	**(3,970)**	**(2,720)**	**(3,000)**
NET SURPLUS / (DEFICIT) after contingency	**(1,822)**	**(1,676)**	**146**	**(7,849)**	**(7,430)**	**419**	**(8,650)**

Headlines against internal Trust plan:

There was a favourable variance of £746k in the month before an additional £600k contribution to contingency. Year to date there has been a favourable variance of £3,139k prior to an additional contingency of £2.7m.

Clinical income was £1,327k above plan for the month, £405k of which relates to a refresh of prior months activity and income.

There are adverse income variances elsewhere due to continued shortfalls against private patient income (£86k) and STF (£45k expected under-performance against the Cancer target).

Pay this month includes a £418k VAT adjustment relating to months 1-5. Medical staffing continues to overspend despite a significant reduction against agency.

The adverse variance on non pay is on drugs and clinical supplies linked to additional activity.

There is a favourable variance against depreciation. Following a review of projected forecast a full year underspend of £800k is now estimated. The variance in month 5 relates to the year to date benefit.

Performance against NHSI plan

	Current Month			Year to Date			Annual
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
NET SURPLUS / (DEFICIT) after contingency	**(493)**	**(1,676)**	**(1,183)**	**(6,884)**	**(7,430)**	**(546)**	**(8,650)**

Headline against NHSI plan

The revised plan submitted to NHSI in June had a different phasing to the Trust's internal plan. The Trust year to date position against NHSI plan is a £546k adverse variance.

Run Rate Analysis - August 2016

	Apr-16 Actual £000s	May-16 Actual £000s	Jun-16 Actual £000s	Jul-16 Actual £000s	Aug-16 Actual £000s	Sep-16 Plan £000s	Oct-16 Plan £000s	Nov-16 Plan £000s	Dec-16 Plan £000s	Jan-17 Plan £000s	Feb-17 Plan £000s	Mar-17 Plan £000s	2016/17 Total £000s
Income													
Income from NHS activities	30,548	30,329	31,903	31,768	31,265	30,698	30,392	30,715	29,061	30,435	29,046	31,766	367,926
Other income	3,736	3,514	6,488	4,388	4,615	4,571	5,153	5,142	5,134	5,129	5,147	5,342	58,358
Total Income	**34,284**	**33,842**	**38,391**	**36,156**	**35,880**	**35,269**	**35,545**	**35,857**	**34,196**	**35,564**	**34,193**	**37,108**	**426,284**
Expenditure													
Pay	(21,174)	(21,185)	(21,419)	(21,317)	(21,705)	(20,942)	(20,917)	(20,914)	(20,913)	(20,940)	(20,942)	(20,993)	(253,362)
Non Pay	(13,846)	(13,164)	(13,619)	(13,257)	(13,517)	(12,902)	(12,604)	(12,594)	(12,589)	(12,621)	(12,625)	(12,619)	(155,957)
Unallocated budgets	(417)	(917)	(1,539)	(1,836)	(1,481)	(993)	(697)	(697)	(697)	(531)	(731)	(765)	(11,301)
Total Expenditure	**(35,437)**	**(35,267)**	**(36,577)**	**(36,410)**	**(36,703)**	**(34,836)**	**(34,218)**	**(34,206)**	**(34,200)**	**(34,092)**	**(34,298)**	**(34,377)**	**(420,621)**
EBIDTA	**(1,153)**	**(1,425)**	**1,813**	**(253)**	**(824)**	**433**	**1,326**	**1,651**	**(4)**	**1,472**	**(105)**	**2,731**	**5,663**
Financing costs	(1,259)	(1,259)	(1,014)	(1,207)	(852)	(1,186)	(1,186)	(1,186)	(1,186)	(1,186)	(1,186)	(1,186)	(13,897)
Profit on sale of land													
Reported Net (Deficit)	**(2,412)**	**(2,684)**	**799**	**(1,460)**	**(1,676)**	**(754)**	**140**	**465**	**(1,191)**	**285**	**(1,292)**	**1,545**	**(8,234)**
Normalised Adjustments:													
CCG funding - assumed in original plan	(458)	(458)	(458)	(375)	(458)	(258)	(258)	(258)	(258)	(258)	(258)	(258)	(4,017)
CCG funding to achieve revised control total							(592)	(592)	(592)	(592)	(592)	(592)	(3,550)
Sustainability & Transformation Funding			(2,675)	(847)	(847)	(892)	(892)	(892)	(892)	(892)	(892)	(892)	(10,611)
Contingency	250	670	1,050	1,150	850	250	250	250	250	250	250	250	5,720
Prior months adjustments:													
NHSP VAT Adjustment	(83)	(83)	(83)	(83)	333								0
High cost drugs	55	(55)											0
NHS Income refresh M3	291	604	(895)										0
NHS Income refresh M4	107	(88)	1,154	(1,173)									0
NHS Income refresh M5	(25)	(34)	(209)	674	(405)								
Finance costs incl Depreciation	141	141	(82)	67	(267)								0
NHSP Medical	(58)	(58)	(175)	60	230								0
Normalised Net (Deficit)	**(2,193)**	**(2,046)**	**(1,573)**	**(1,988)**	**(2,239)**	**(1,654)**	**(1,352)**	**(1,027)**	**(2,682)**	**(1,206)**	**(2,783)**	**53**	**(20,691)**
Actual/Forecast (Deficit) per calendar day	**(73)**	**(66)**	**(52)**	**(64)**	**(72)**	**(55)**	**(44)**	**(34)**	**(89)**	**(40)**	**(93)**	**2**	**(57)**

Headlines:

The planned deficit in the second half of the year is breakeven, compared with a £8.6m deficit in the first half of the year. This is mainly as a result of a step up in CIP delivery and assumed additional CCG support funding (£3.6m).

The monthly variations in planned I&E are mainly as a result of income phasing relating to working and calendar days.

The reported run rate position for recent months has shown movements month to month. This has partly been due to the non-operational issues explained here.

The main normalised adjustments for August are:

- Inclusion of £850k contingency
- Redistribution of expected costs re NHSP VAT across months 1-5
- Impact of income refresh where month 5 reported income includes a positive benefit of £405k from previous months
- Redistribution of expected benefit re Depreciation (£333k) favourable variance across months 1-5
- NHSP Medical staffing cancelled shifts transferred to previous relevant months.

Activity and Contract Income - August 2016

Prior year actual YTD Month 4	Activity	Current Month Plan	Current Month Actual	Current Month Variance	Current Month %	Year to Date Plan	Year to Date Actual	Year to Date Variance	Year to Date % Var	Annual Plan
7,552	Day Cases	1,949	2,497	548	28	9,984	11,480	1,496	15	24,347
4,003	Elective	912	655	(257)	(28)	4,699	3,644	(1,055)	(22)	11,429
15,218	Non Elective	3,830	3,832	2	0	18,725	18,247	(478)	(3)	45,702
26,773	***Total Inpatients***	***6,691***	***6,984***	***293***	***4***	***33,408***	***33,371***	*(37)*	*(0)*	***81,478***
6,772	*Excess bed days*	1,705	1,596	(109)	(6)	8,476	7,086	(1,390)	(16)	*20,264*
6,772	***Total Excess bed days***	**1,705**	**1,596**	**(109)**	**(6)**	**8,476**	**7,086**	**(1,390)**	**(16)**	***20,264***
33,072	Consultant first attendance	8,184	8,660	476	6	42,475	43,133	658	2	103,004
57,896	Consultant follow up	14,186	14,859	673	5	73,764	77,164	3,400	5	178,733
19,048	Outpatient Procedures	5,635	6,996	1,361	24	28,525	34,134	5,609	20	69,992
55,902	Other outpatients	15,232	16,465	1,233	8	77,417	77,411	(6)	(0)	188,601
165,918	***Total Outpatients***	***43,237***	***46,980***	***3,743***	***9***	***222,181***	***231,842***	***9,661***	***4***	***540,330***
47,675	A&E attendances	13,270	12,918	(352)	(3)	65,465	66,423	958	1	156,216
26,592	Renal Dialysis	6,525	7,164	639	10	33,903	35,437	1,534	5	82,129
2,024	Adult Critical Care	619	563	(56)	(9)	3,054	3,232	178	6	7,287
1,837	Maternity Births	500	453	(47)	(9)	2,468	2,360	(108)	(4)	5,907
51,487	Mount Vernon	13,116	13,093	(23)	(0)	66,185	65,838	(347)	(1)	160,196

Headlines:

The main driver for Over performance in Admitted patient care continues to be Day Case activity which is due to additional waiting list sessions being put on, principally by Surgery for T&O, Oral Surgery and Opthalmology.

Outpatient Procedures continues to be above plan for all Divisions . Consultant and Non Consultant attendances are also significantly above plan.

A&E activity dipped below plan in August seeing 12,918 attendances (12,188 A&E [94%]and 730 Urgent Eye[6%]). The underperformance is 311 attendances for A&E and 41 for Urgent Eye.

Maternity saw the number of births dip in M5 to the lowest seen this year at 455 births in the month.

Prior year actual YTD Month 4	Income	Current Month Plan £000s	Current Month Actual £000s	Current Month Variance £000s	Current Month Var %	Year to Date Plan £000s	Year to Date Actual £000s	Year to Date Variance £000s	Year to Date Var %	Annual Plan £000s
7,692	Day Cases	1,615	2,209	594	37	8,275	9,901	1,626	20	20,190
7,383	Elective	1,787	1,999	212	12	9,242	9,382	140	2	22,433
26,677	Non Elective	6,447	6,763	316	5	31,136	33,439	2,303	7	75,334
41,752	***Total Inpatients***	**9,849**	**10,971**	**1,122**	**11**	**48,653**	**52,722**	**4,069**	**8**	**117,957**
1,401	Excess Bed days	430	406	(24)	(6)	2,139	1,807	(332)	(16)	5,114
1,401	***Total Excess bed days***	**430**	**406**	**(24)**	**(6)**	**2,139**	**1,807**	**(332)**	**(16)**	**5,114**
6,117	Consultant first attendance	1,430	1,516	86	6	7,423	7,633	210	3	18,001
6,418	Consultant follow up	1,451	1,421	(30)	(2)	7,543	7,839	296	4	18,277
4,630	Outpatient Procedures	948	1,199	251	26	4,868	5,829	961	20	11,850
6,127	Other outpatients	1,453	1,673	220	15	7,438	7,800	362	5	18,122
23,293	***Total Outpatients***	**5,282**	**5,809**	**527**	**10**	**27,272**	**29,101**	**1,829**	**7**	**66,250**
6,466	A&E attendances	1,535	1,589	54	4	7,549	8,055	506	7	18,050
4,326	Renal Dialysis	1,022	1,118	96	9	5,300	5,443	143	3	12,832
3,567	Adult Critical Care	839	741	(98)	(12)	4,142	4,308	166	4	9,884
9,089	Maternity	2,407	1,828	(579)	58	11,951	10,917	(1,034)	(27)	28,656
17,722	Mount Vernon	4,096	4,216	120	3	21,993	21,938	(55)	(0)	53,944
6,837	Drugs	1,615	1,994	379	23	8,644	8,831	187	2	20,147
7,965	Other Non-PbR cost & volume	2,359	1,995	(364)	(15)	10,463	9,960	(503)	(5)	23,858
2,129	Acute CQUIN	504	598	94	19	2,520	2,727	207	8	6,049
124,547	**Total NHS Income**	**29,938**	**31,265**	**1,327**	**4**	**150,626**	**155,809**	**5,183**	**3**	**362,741**

Headlines:

Clinical income was £1.3m above plan in the month of which £0.4m relates to prior months refresh.

There is a significant overperformance in Non Elective income, despite activity being behind plan both in the month and year to date. The Trust is working closely with ENHCCG and the information team to understand the drivers behind this price mix increase . The impact of refreshing prior months income is £19k, with month 5 income being £297k above plan.

The income for A&E is now delivering in line with Activity levels .

Maternity underperformance has been mitigated by reaching an agreement with PAH regarding booking of Antenatal pathways, however, challenges validated with Herts Valley have led to a decrease in chargeable activity.

There continues to be an exceptional impact of the refresh of prior months income in month 5. The income team are working alongside information and operational colleagues to understand and address timeliness of information and coding backlog.

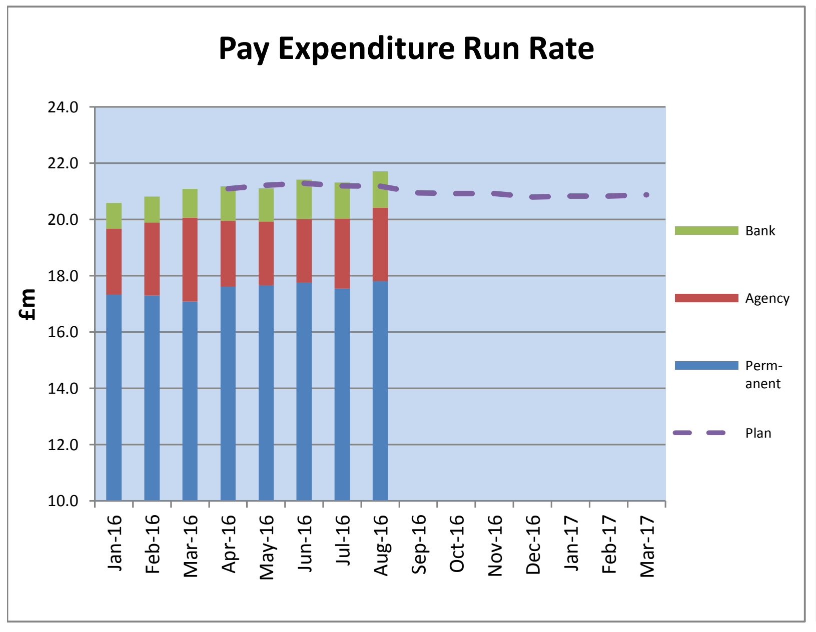
Expenditure -August 2016

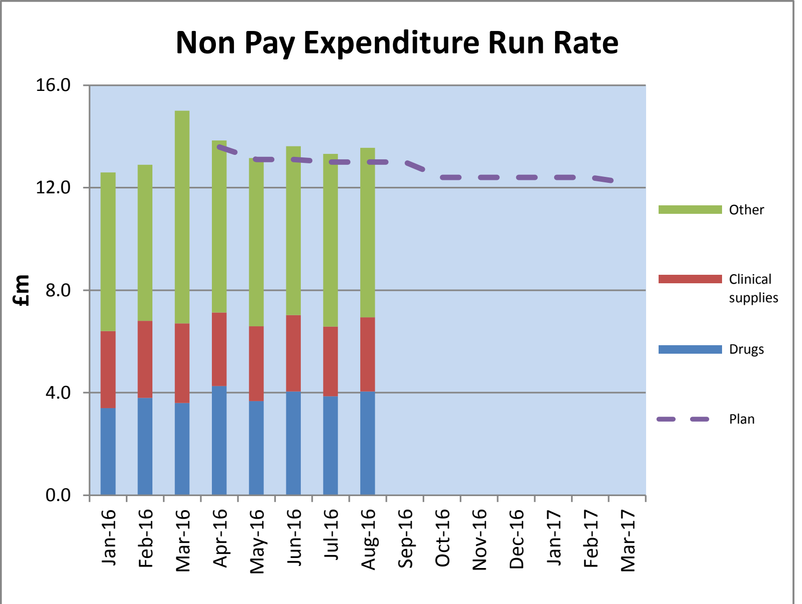
Prior year actual YTD	Staff group	Current Month Plan	Current Month Actual	Current Month Variance	Current Month % Var	Year to Date Plan	Year to Date Actual	Year to Date Variance	Year to Date % Var	Annual Plan
	Pay									
31,940	Nursing	6,929	6,691	238	3%	34,566	33,942	623	2%	82,864
31,278	Medical	6,732	6,867	(135)	(2%)	33,722	34,226	(505)	(1%)	79,604
20,419	Other Clinical	4,206	4,553	(346)	(8%)	21,141	21,985	(845)	(4%)	50,879
14,485	Non Clinical	3,315	3,596	(280)	(8%)	16,537	16,647	(110)	(1%)	39,179
98,122	**Total Pay**	**21,183**	**21,706**	**(524)**	**(2%)**	**105,965**	**106,802**	**(837)**	**(1%)**	**252,526**
	Non Pay									
18,051	Drugs	3,952	4,044	(93)	(2%)	19,306	19,825	(520)	(3%)	45,481
13,327	Clinical Supplies	2,743	2,926	(183)	(7%)	13,985	14,404	(420)	(3%)	33,480
28,654	Other	6,496	6,546	(50)	(1%)	33,009	33,172	(163)	(0%)	75,892
60,031	**Total Non Pay**	**13,191**	**13,517**	**(326)**	**(2%)**	**66,299**	**67,402**	**(1,103)**	**(2%)**	**154,853**
158,153	**Total Expenditure**	**34,373**	**35,223**	**(850)**	**0**	**172,264**	**174,203**	**(1,940)**	**0**	**407,379**

Headlines - Variances from plan:

Pay:
The Month 5 position includes an estimate of the impact of outstanding NHSP VAT charges from April to August (£418k). Without this charge the monthly variance would have been in line with recent months.

Non-Pay:
There was an adverse variance driven by activity against clinical supplies and drugs in Medical (£74k), Surgery (£62k) and Womens & Childrens (£43k).





Headlines - Run Rate

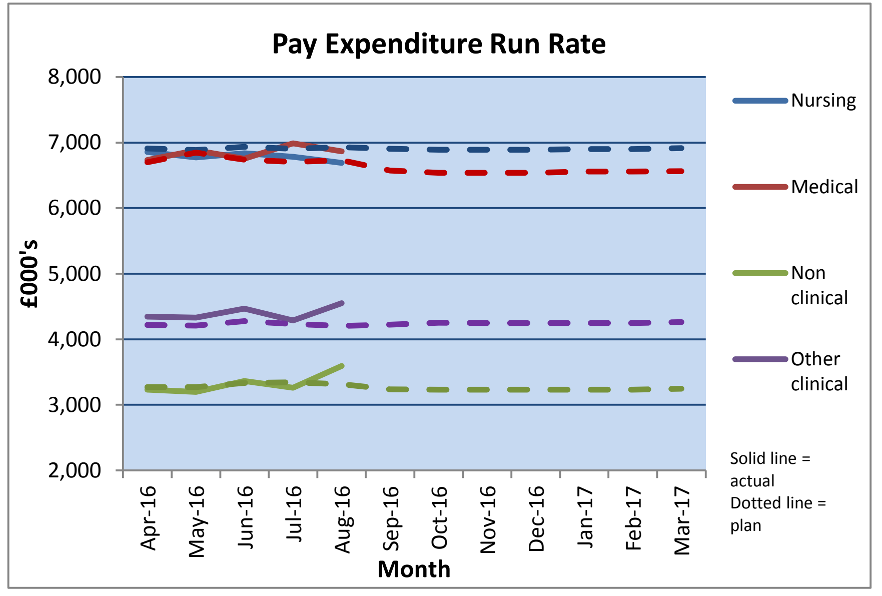
Pay:
Allowing for the VAT adjustment, total pay decreased from month 4 by £29k. Within this, spend on substantive staff has risen by £272k offset by a reduction in agency of £301k. The substantive movement includes an increase in waiting list spend of £122k.

Non-pay:
Monthly volatility in levels of overall spend mostly reflect changes against drugs which has fluctuated all year. Other spend has been quite steady: when Clinical Supplies spend has dipped due to lower internal activity there has been an increase in outsourced costs appearing in Other Costs.

Pay Expenditure - August 2016

		Apr-16 £000s	May-16 £000s	Jun-16 £000s	Jul-16 £000s	Aug-16 £000s	Sep-16 £000s	Oct-16 £000s	Nov-16 £000s	Dec-16 £000s	Jan-17 £000s	Feb-17 £000s	Mar-17 £000s	YTD £000s
Nursing	*Plan*	6,910	6,887	6,933	6,907	6,929	6,906	6,890	6,891	6,891	6,900	6,901	6,918	34,566
	Actual	6,859	6,774	6,837	6,782	6,691								33,942
	Variance	51	113	96	125	238								623
Medical	*Plan*	6,699	6,846	6,739	6,706	6,732	6,574	6,541	6,542	6,541	6,559	6,560	6,566	33,722
	Actual	6,735	6,881	6,755	6,988	6,867								34,226
	Variance	(36)	(35)	(16)	(282)	(135)								(505)
Non Clinical	*Plan*	3,269	3,271	3,335	3,347	3,315	3,235	3,233	3,233	3,232	3,232	3,232	3,246	16,537
	Actual	3,232	3,198	3,362	3,260	3,596								16,647
	Variance	37	73	(27)	87	(280)								-110
Other Clinical	*Plan*	4,218	4,209	4,276	4,232	4,206	4,226	4,254	4,249	4,249	4,249	4,249	4,263	21,141
	Actual	4,348	4,332	4,466	4,287	4,553								21,985
	Variance	(130)	(123)	(190)	(55)	(346)								(845)
Total	***Plan***	**21,095**	**21,213**	**21,283**	**21,192**	**21,183**	**20,942**	**20,917**	**20,914**	**20,913**	**20,940**	**20,942**	**20,993**	**105,965**
	Actual	**21,174**	**21,185**	**21,419**	**21,317**	**21,706**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**106,802**
	Variance	**(79)**	**27**	**(136)**	**(125)**	**(524)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(837)**

Waiting Lists spend included in above		381	419	422	402	**491**								2,115



Headlines:

NHSP VAT: It has been identified that the Trust has over-reclaimed VAT on invoices from NHSP. This issue is currently being pursued with Shared Business Services and our VAT advisors to validate the value of the overclaim and necessary actions to rectify this issue. In the meantime, an estimate of the impact on the financial position year-to-date (£418k) has been included in the month 5 position. The only affected groups are Other Clinical (£170k) and Non Clincal (£248k).

Nursing - Nursing saw a reduction this month on agency (£67k) and bank (£77k). £219k of the nursing underspend is in the Medical Division. Overall, Nursing and CSWs (shown in Other Clinical, below) continue to have offsetting variances (£238k and £231k respectively).

Medical - There is a reduction compared with month 4 largely due to release of NHSP shifts (£230k) but the overspend persists. The largest variance is within Surgery (£199k, offset by underspends in Medicine and Cancer) of which £62k is above plan spend on waiting lists, which was at the highest level all year.

Other Clinical - Excluding VAT the variance reduces to £176k, this includes £231k adverse on CSWs and £55k favourable on other support staff.

Non-Clinical: Excluding VAT the adverse variance reduces to £32k. This is in line with previous spend and includes agency spend in Corporate departments.

Agency Expenditure - August 2016

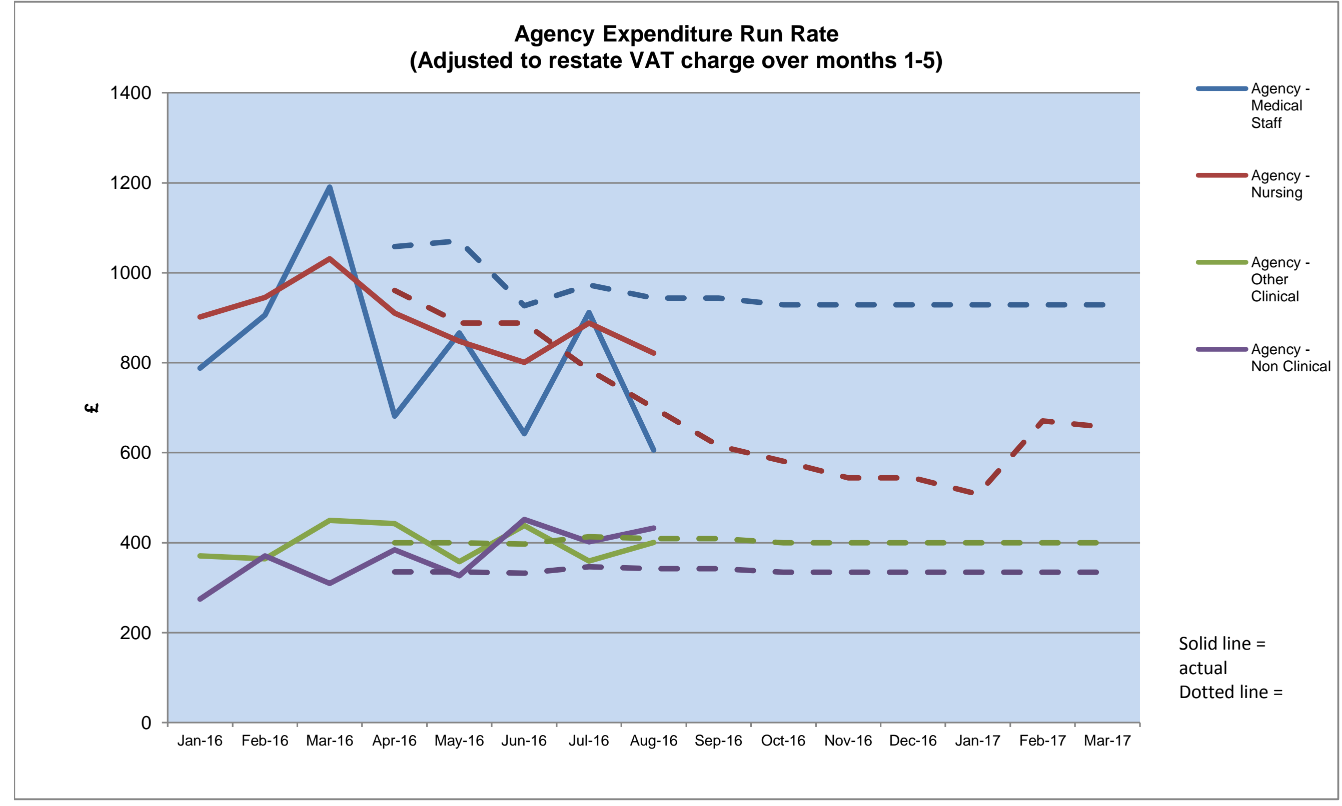
Prior year actual YTD	Staff group	Current Month Plan	Current Month Actual	Current Month Variance	Current Month Premium	Year to Date Plan	Year to Date Actual	Year to Date Variance	Year to Date Premium	Annual Plan
3,581	Nursing	700	821	(121)	175	4,221	4,268	(46)	907	8,421
2,752	Medical	944	606	338	247	4,973	3,708	1,265	1,514	11,284
1,516	Other Clinical	409	536	(128)	130	2,018	1,998	20	484	5,093
1,205	Non clinical	342	631	(288)	207	1,691	1,996	(305)	656	3,771
9,055	**Total**	**2,395**	**2,594**	**(199)**	**760**	**12,903**	**11,969**	**934**	**3,562**	**28,569**

Headlines - against NHSI plan:

Excluding the £418k VAT adjustment ,the monthly position was £219k favourable variance to plan. The expected full year impact on agency figures of the VAT adjustment is £1.0m. There is a further risk of approximately £2.0m if our auditors and NHS I do not agree that the previous years impact could be treated as a prior year adjustment.

Premium Element

Of the actual spend the premium is an estimation of how much is paid in excess of costs if work was completed by substantive staff. The agency cap of 55% excludes employer oncosts, once these are factored in the gap between substantive and agency rates reduce. Current premium rates have been estimated to range from 27% in nursing to an average 69% for medical staff. Across all groups the weighted average is 44%. This represents the maximum potential saving if agency use were reduced, of the year to date spend this value is £3,562k.

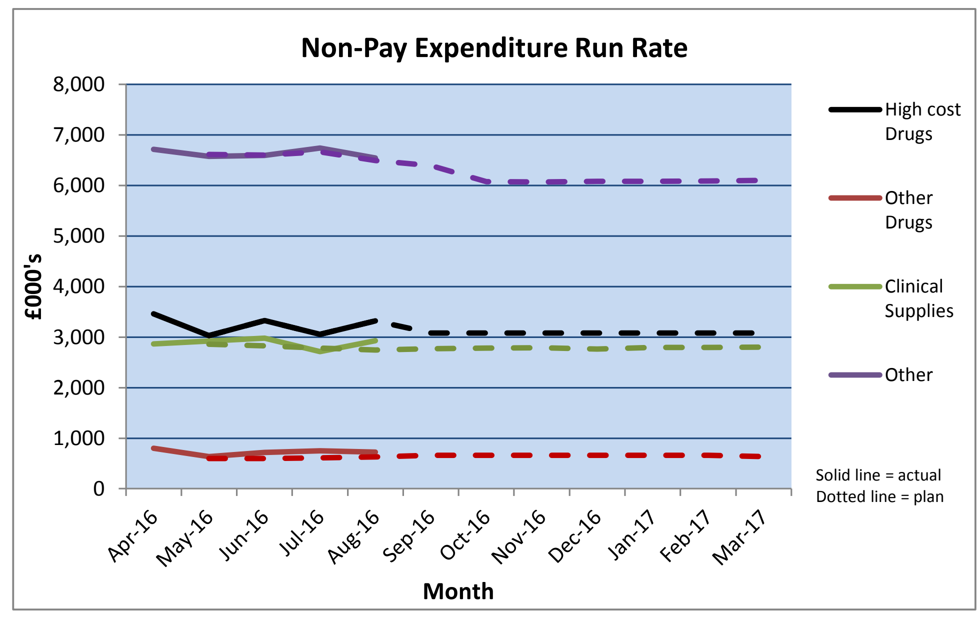


Headlines - agency run rate

Nursing - The decrease since mth 4 (£67k) is due to the reduced fill rate (from 79% to 71%). This is partly seasonal but also reflects changes within the temporary staffing control environment, including a new restriction on which requested shifts are made available to agencies. Despite this, and other increases in the control environment this year, the adverse variance continues because the actual rates of recruitment and, to a lesser extent, attrition have both been worse than planned.
Medical - Robust data regarding medical usage has been unavailable since the introduction of the NHSP Connect system. Departments have provided updates regarding missing data and despite best efforts this has resulted in some volatility, as shown on the graph. The dataset provided for month 5 was the most complete yet and this enabled a data cleanse exercise. This has resulted in a lower monthly figure, with the vast majority of the movement in Medicine. The benefit in month includes £230k worth of expected costs relating to previous months being removed. The ongoing housekeeping work in departments should improve following new rota and agency booking appointments to support correct use of the new system.
Other Clinical - Excluding the impact of the VAT adjustment (£170k) leaves a favourable variance of £42k against the expected plan. This is partly due to restrictions on agency CSWs, where spend is £15k lower than month 4.
Non Clinical - Excluding the impact of the VAT adjustment (£248k) leaves an adverse variance of £40k against the expected plan, mainly due to usage in Corporate Services.

Non-Pay Expenditure - August 2016

		Apr-16 £000s	May-16 £000s	Jun-16 £000s	Jul-16 £000s	Aug-16 £000s	Sep-16 £000s	Oct-16 £000s	Nov-16 £000s	Dec-16 £000s	Jan-17 £000s	Feb-17 £000s	Mar-17 £000s	YTD £000s
High Cost Drugs	*Plan*	3,463	3,033	3,328	3,057	3,319	3,082	3,082	3,082	3,082	3,082	3,082	3,082	16,200
	Actual	3,463	3,033	3,328	3,057	3,319								16,200
	Variance	0	0	0	0	0								0
Drugs	*Plan*	666	597	600	610	633	661	661	661	661	661	661	638	3,106
	Actual	800	635	717	748	725								3,626
	Variance	(134)	(38)	(117)	(138)	(93)								(520)
Clinical Supplies	*Plan*	2,772	2,858	2,827	2,784	2,743	2,768	2,785	2,786	2,766	2,795	2,793	2,801	13,985
	Actual	2,866	2,920	2,980	2,713	2,926								14,404
	Variance	(94)	(61)	(153)	71	(183)								(420)
Other	*Plan*	6,633	6,615	6,599	6,665	6,496	6,391	6,076	6,066	6,081	6,084	6,089	6,098	33,009
	Actual	6,717	6,577	6,592	6,740	6,546								33,172
	Variance	(84)	38	7	(75)	(50)								(163)
Total	***Plan***	**13,534**	**13,103**	**13,355**	**13,117**	**13,191**	**12,902**	**12,604**	**12,594**	**12,589**	**12,621**	**12,625**	**12,619**	**66,299**
	Actual	**13,845**	**13,164**	**13,618**	**13,258**	**13,517**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**67,402**
	Variance	**(311)**	**(62)**	**(263)**	**(141)**	**(326)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(1,103)**



Headlines:

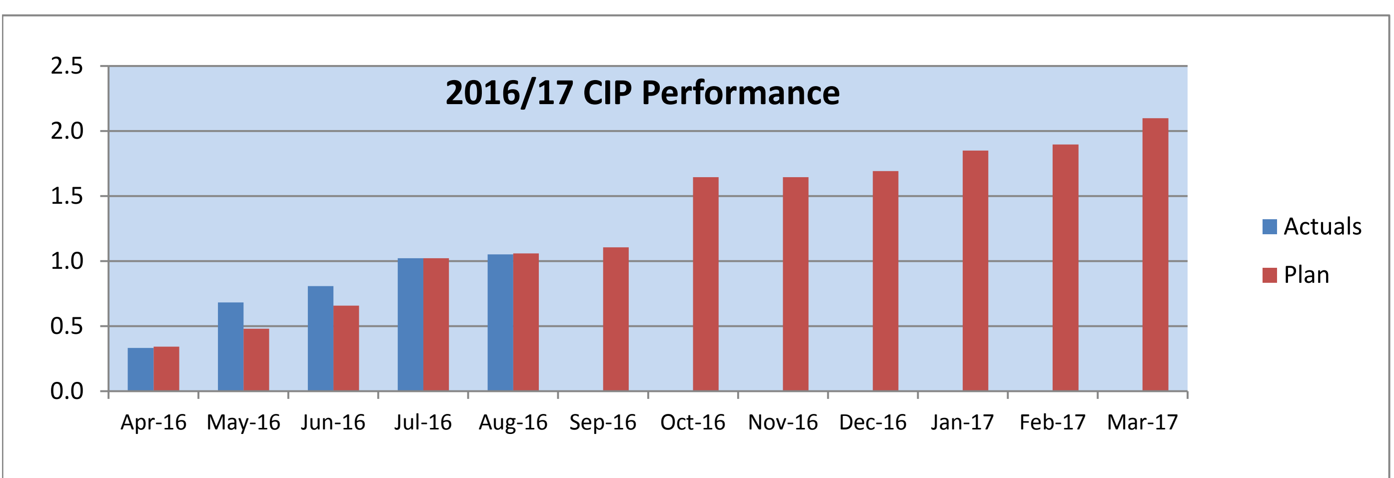
High Cost Drugs: These are 'pass through' costs funded by Commissioners so there is nil variance each month.

Other Drugs: Month 5 is in line with average spend so far this year. The adverse variance to plan is in Surgery (£44k activity driven) and in Renal (£40k includes some previous period costs for home dialysis drugs). The Chief Pharmacist is working with clinical divisions on a review of drugs spend to establish whether variances are due to changes in activity, price or clinical practise.

Clinical Supplies: In the Medical Division there is £74k adverse variance largely due to above plan activity on daycases in Cardiology leading to higher spend on stents and disposable equipment. Activity levels have also driven higher spend in Surgery (£62k) and Womens & Childrens (£43k).

Other: This month Cancer had above plan activity on scans (£31k) and under-performance against CIPs (£30k). Both spend and budget are lower this month following month 4 spikes in outsourcing and costs relating to overseas recruitment. Budgets are planned to reduce

Cost Improvement Programme - August 2016



Division	In Month Plan £000s	In Month Actual £000s	In Month Variance £000s	Year to Date Plan £000s	Year to Date Actual £000s	Year to Date Variance £000s	Annual Plan £000s	YTD Var to annual plan £000s
Medical	10	24	14	35	174	139	1,091	917
Surgical	206	236	30	492	617	125	2,399	1,782
Womens & Childrens	12	7	(5)	48	37	(11)	133	96
Cancer	43	46	3	144	227	83	1,839	1,612
Clinical Support	80	78	(2)	357	382	25	1,160	778
Corporate/Trustwide	200	192	(7)	684	631	(53)	3,162	2,531
Expenditure Total	**551**	**584**	**33**	**1,761**	**2,068**	**308**	**9,784**	**7,716**
Medical	111	203	92	382	801	420	1,247	446
Surgical	79	47	(32)	308	204	(104)	1,009	805
Womens & Childrens	104	62	(43)	425	282	(143)	1,211	929
Cancer	55	20	(35)	191	57	(134)	577	520
Clinical Support	46	42	(4)	215	189	(26)	533	344
Corporate/Trustwide	115	95	(20)	282	217	(65)	1,139	922
Income Total	**510**	**468**	**(42)**	**1,801**	**1,750**	**(52)**	**5,716**	**3,966**
CIP Total	**1,061**	**1,053**	**(9)**	**3,562**	**3,818**	**256**	**15,500**	**11,682**

Headlines:

The CIP profile assumes greater levels of delivery as the year progresses.

In month delivery is 99% with 107% for the year to date.

Expenditure CIPs have over-delivered in month and year to date in total, with small in month adverse variances in Women's and Childrens, Clinical Support and Corporate.

Income CIPs have underperformed across the Trust except in the **Medical** division with continued over-delivery against their coding scheme (£93k).

Elsewhere, adverse variances include:

- **Surgery** - a delay in comorbidities and complications coding (£25k).
- **Womens and Childrens** - two schemes have been delayed until September (£35k) and another (antenatal activity for Barnet patients) will not deliver.
- **Cancer** - the cyberknife performance has improved though still not at planned levels (£10k), schemes reliant on recruiting patients are also under (£16k).
- **Corporate** - the BIMs/PAS reconciliation (£8k) has not delivered yet this year and the timing of a delayed car parking charge scheme (£11k) , which is currently under review.

Divisional Analysis (High Level Variances) - August 2016

In Month Variance	Income: Clinical Income £000s	Income: Other Income £000s	Income: Total Income Variance £000s	Expenditure: Pay £000s	Expenditure: Non Pay £000s	Expenditure: Total Expenditure Variance £000s	Net I&E Variance £000s	Year to date I&E variance £000s	Breakdown of in-month expenditure variances: Operational/ Activity £000s	CIP £000s	Other (incl vacancies) £000s	Total Expenditure £000s
Medical	954	0	954	174	(130)	44	**998**	3,109	(176)	14	206	44
Surgical	1,040	(17)	1,023	(324)	(76)	(400)	**623**	1,822	(322)	30	(108)	(400)
Womens & Childrens	(524)	(6)	(530)	(25)	(59)	(83)	**(613)**	(1,439)	(99)	(5)	21	(83)
Cancer	75	(39)	36	97	(103)	(6)	**30**	(79)	(54)	3	45	(6)
Clinical Support	385	54	439	(21)	(34)	(54)	**385**	177	(20)	(2)	(32)	(54)
Corporate/Other	(605)	(95)	(700)	(424)	113	(311)	**(1,011)**	(793)	30	(7)	(334)	(311)
EBIDTA	**1,325**	**(103)**	**1,222**	**(522)**	**(289)**	**(810)**	**412**	**2,797**	**(641)**	**33**	**(202)**	**(810)**

Divisional Variances - Headlines

Medical - The favourable variance of £954k includes above plan income of £461k on inpatients across a number of specialities. The previous months refresh was favourable and worth £149k. Pay was under plan driven by a large one off benefit regarding NHSP medical shifts. The ongoing nursing underspend increased from £59k to £219k due to da lower agency shifts fill rate i n the month. The non pay overspend includes £74k activity driven spend on clinical supplies, including £45k in Cardiology, and drugs in Renal (£40k).

Surgical - The favourable income variance includes £570k relating to the refresh of previous periods. The in-month position of £470k compares with an adverse expenditure position but additional income is expected to be identified during month 6 that will compensate . The above plan income came from day cases (£392k T&O and plastic surgery), non elective (£131k) and elective (£118k) offset by below plan activity in Adult Critical Care (£192k). Adverse variance on expenditure was activity driven and is predominantly in pay (£199k medical of which £62k is Waiting Lists), £84k other clinical, £49k on nursing of which £79k is Waiting Lists) but there was also £62k variance to plan on clinical supplies in theatres and Orthopaedics. The £108k adverse variance against 'other', above, relates to agency premium paid against medical vacancies in general surgery and anaesthetically trained nurses £52k) . There were also some revisions to NHSP Connect shifts from prior months £58k).

Womens & Childrens - The adverse position on clinical income was £409k for the month, made worse by a refresh impact of £115k. The shortfall mainly comes from maternity pathway (£234k in month, £1,078k year to date). This month also saw Paediatric non elective activity below plan contributing an adverse variance of £161k. However elective activity and income are above plan (£90k) due to additional Gynae waiting lists which also contributed to above plan spend (£43k on clinical supplies).

Cancer - The in-month position on clinical income was a £149k favourable variance but it was reduced by £75k relating to previous months. The areas above plan were Acute drugs (£71k) and Radiotherapy (£67k). Local income has an adverse variance relating to private patients though there has been a significant improvement over month 4 performance. The month again saw a favourable pay variance (£325k year to date) relating to vacant posts including over-delivery on vacancy CIPs (£28k). The non pay adverse variance includes undelivered CIPs (£25k) and higher scan activity (£31k).

Clinical Support - The in-month clinical income position was £131k before the additional contribution of £255k from previous months. The in-month variances came from above plan performance on diagnostic imaging (£55k, £235k year to date) and from PBR drugs (£90k) where a joint Finance/Pharmacy review of process and classifications should lead to increased recovery of costs from commissioners. Adverse variances on expenditure relate to agency premium in Pharmacy (6wte) and above plan costs on non-pay in OPD and Radiology

Corporate/Other - The clinical income adverse variance relates to adjustments not allocated out to departments. This month the adverse variance includes £475k threshold adjustment (30% adjustment) on non-elective activity, £225k provision for VAT High Cost Drugs gainshare with NHSE and a favourable overperformance of £95k for CQUIN. The local income figure has an adverse variance reflecting the expected underperformance against the STF Cancer target (£45k) and the funding gap regarding the Urgent Care Centre (£83k). The large pay variance for the month relates to 5 months worth of the NHSP VAT additional charge (£418k). The favourable variance on non pay includes below plan spend on international nurse recruitment and against contractual payments in Facilities.

12 Month Rolling Cashflow - August 2016

	Aug-16 £000 *Actual*	Sep-16 £000 *Forecast*	Oct-16 £000 *Forecast*	Nov-16 £000 *Forecast*	Dec-16 £000 *Forecast*	Jan-17 £000 *Forecast*	Feb-17 £000 *Forecast*	Mar-17 £000 *Forecast*	Apr-17 £000 *Forecast*	May-17 £000 *Forecast*	Jun-17 £001 *Forecast*	Jul-17 £001 *Forecast*
Opening Balance	**1,446**	**1,454**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**
Receipts												
NHS Acute Activity Income	31,653	32,232	31,889	31,622	31,562	31,924	29,460	35,254	32,587	32,587	32,587	32,587
S&T Funding	2,675	0	0	2,675	0	2,675	0	2,675	0	0	0	0
Education/Merit awards/R&D	930	869	869	869	869	869	869	869	869	869	869	869
Other income	2,821	2,646	2,646	2,756	2,677	2,677	2,706	2,892	2,892	2,892	2,892	2,892
Interest	3	3	3	2	3	3	3	2	2	2	2	2
Sale of Non-current assets	0	0	0	0	0	0	0	1,800	0	0	0	0
Interim Revolving Working Capital Support (IRWCS)	0	1,907	0	0	0	0	0	0	0	0	0	0
Interim Revenue Support Loan	0	0	0	9,255	0	0	0	2,593	0	0	0	0
Strategic Capital Loans	787	684	598	605	1,357	1,528	1,527	1,603	0	0	0	0
PDC Received	0	0	0	0	0	0	0	0	0	0	0	0
Sub-total Receipts	**38,869**	**38,341**	**36,005**	**47,784**	**36,468**	**39,676**	**34,565**	**47,688**	**36,350**	**36,350**	**36,350**	**36,350**
Salaries & Wages	10,505	10,256	10,256	10,256	10,256	10,256	10,256	10,256	10,256	10,256	10,256	10,256
PAYE / Superannuation/ NI	7,682	7,790	7,790	7,790	7,790	7,790	7,790	7,790	7,790	7,790	7,790	7,790
Creditors	20,637	14,930	17,959	20,483	18,422	21,630	16,416	25,932	18,304	18,304	18,304	18,304
Dividend Paid	0	534	0	0	0	0	0	1,167	0	0	0	0
Interest on DH CILs	0	800	0	0	0	0	0	769	0	0	0	0
Repay IRWCS	0	2,675	0	9,255	0	0	0	0	0	0	0	0
Interest on IRWCS	0	516	0	0	0	0	0	480	0	0	0	0
Repay Interim Rev Support Loan	0	0	0	0	0	0	0	0	0	0	0	0
Interest on Int. Rev. Support Loan	37	0	0	0	0	0	103	0	0	0	0	0
PDC 1% fee	0	0	0	0	0	0	0	0	0	0	0	0
DH Loan Repayments - CIL	0	1,294	0	0	0	0	0	1,294	0	0	0	0
DH Loan Repayments - HCA	0	0	0	0	0	0	0	0	0	0	0	0
Sub-total Payments	**38,861**	**38,795**	**36,005**	**47,784**	**36,468**	**39,676**	**34,565**	**47,688**	**36,350**	**36,350**	**36,350**	**36,350**
Net in Month Cash Movement	**8**	**(454)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Closing Balance	**1,454**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**
Trust Cash plan	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**

Headllines:

The cash balance at the end of August 2016 was £1.4m, which was £400k higher than the minimum balance required as a condition of our working capital support.

The resubmitted planned deficit for 2016/17 shows that the Trust requires working capital support of £12.876m (£8.650m in relation to the revised 2016/17 deficit and a further £4.226m because the 2015/16 deficit was higher than forecast).

In September the Trust will be obliged to repay £2.675m of its IRWCS as that amount of the borrowing was an advance of Q1 S&T funding which has been received in August. However The Trust will then be able to borrow a further £1.907m against the deficit.

It is anticipated that the majority of IRWCS received in 2016/17 will be converted to Interim Revenue Support Loan in November 2016.
Strategic Loan receipts have been rephased since the initial forecast. There is considerable uncertainty over the timing of these funds as most projects have yet to be approved by DH.
In August the Trust received the first draw of the Strategic Capital Loan which is funding the Lorenzo project. Further draws are anticipated each month.

£150k was received in June for the sale of a parcel of QE2 land to the hospice. The sale of the care home is expected to complete by March 2017.

The plan for the remainder of the financial year is to end each month with a balance of £1.0m which is the minimum permitted by the Department of Health.

Capital Programme - August 2016

Capital Programme	Annual plan capital spend to achieve CRL	Forecast Expenditure to 31 March 2017	Forecast year end Variance	YTD Plan	YTD Expenditure	YTD Variance	Capital Commitments	Headlines:
IM&T								
Network Support Infrastructure	150.0	150.0	-	-	32.0	32.0		
Pharmacy Stock Control Project	450.0	450.0	-	-	13.9	13.9		
Other 16/17 projects	400.0	400.0	-	300.0	124.3	(175.7)	220.0	
TOTAL IM&T	1,000.0	1,000.0	-	300.0	170.2	(129.8)	220.0	
MEDICAL EQUIPMENT								
Trust wide equipment	1,000.0	1,000.0	-	300.0	233.1	(66.9)	-	
TOTAL MEDICAL EQUIPMENT	1,000.0	1,000.0	-	300.0	233.1	(66.9)	-	
ESTATES								
Main Hospital Chimney Flue Relining	250.0	250.0	-	-	-	-		
Substation 5 - Blue Panel	250.0	250.0	-	-	-	-		
D1 Pump Replacement	170.0	170.0	-	-	-	-		
Other Estates 16-17 Allocation	330.0	330.0	-	300.0	46.2	(253.8)	440.9	
TOTAL ESTATES	1,000.0	1,000.0	-	300.0	46.2	(253.8)	440.9	
OTHER CAPITAL								
Capitalisation of project costs - 16/17	2,000.0	2,000.0	-	300.0	284.9	(15.1)	21.6	
Other 16/17 schemes	500.0	500.0	-	-	62.7	62.7	-	
TOTAL OTHER	2,500.0	2,500.0	-	300.0	347.6	48	21.6	
TOTAL - TRUST OPERATIONAL SCHEMES	**5,500.0**	**5,500.0**	**-**	**1,200.0**	**797.1**	(402.9)	**682.5**	Expenditure on Trust Operational Schemes is expected to revert to forecast levels by year end.
STRATEGIC SCHEMES								
Salix Steam Pumps	-	345	(345.0)	-	-	-		
Lorenzo EPR	5,427	5,427	-	1,570	489.3	(1,080.7)	303.3	
Linacs	2,212	2,212	-		-	0		
Renal Reconfiguration	2,758	1,379	1,379.0	1,211	-	(1,211.0)		The timing of expenditure against the Renal scheme is in the process of being reassessed.
New Beds	2,200		2,200.0	-	-	0	-	
TOTAL - TRUST STRATEGIC SCHEMES	**12,597**	**9,363**	**3,579**	**2,781**	**489**	**(2,292)**	**303**	
TOTAL CAPITAL	**18,097**	**14,863**	**3,579**	**3,981**	**1,286**	**(2,695)**		

Balance Sheet - Aug 2016

	Opening Balance as at 01/04/16 £000	Balance Sheet as at 31/08/16 £000	Forecast as at 31/03/17
FIXED ASSETS			
Property, Plant Equipment	187,801	185,783	193,076
Trade & Other Receivables Non-Current	2,562	2,562	2,562
Other Financial Assets	2,505	2,505	2,505
TOTAL FIXED ASSETS	**192,868**	**190,850**	**198,143**
CURRENT ASSETS			
Inventories	5,264	5,264	4,264
Cash & Cash Equivalents	15,863	1,454	1,000
Trade & Other Receivables - Current	41,513	54,964	40,140
Assets Held for Sale - QE2	1,700	1,700	0
TOTAL CURRENT ASSETS	**64,340**	**63,382**	**45,404**
Creditors: Amounts Falling Due Within One Year	(74,796)	(67,438)	(52,457)
NET CURRENT ASSETS (LIABILITIES)	**(10,456)**	**(4,056)**	**(7,053)**
FIXED & NET CURRENT ASSETS LESS CURRENT LIABILITIES	**182,412**	**186,794**	**191,090**
Creditors: Amounts Falling Due More Than One Year	(94,080)	(105,889)	(111,405)
Provisions For Liabilities & Charges	(771)	(774)	(774)
NET ASSETS	**87,561**	**80,131**	**78,911**
FINANCED BY			
TAXPAYERS EQUITY:			
Public Dividend Capital	169,950	169,950	169,950
Revaluation Reserve	45,069	45,069	45,069
Retained Earnings	(127,458)	(134,888)	(136,108)
TOTAL TAXPAYERS EQUITY	**87,561**	**80,131**	**78,911**

Headlines:

Other Financial Assets consists of £1m ENH Pharma and £1.505m tPP.

Cash at 1st April was high due to QEII land receipts received 31st March 2016. The balance as at 31st August is above the minimum £1m requirement.

The proceeds from sale of QE11 land was received on 31 March hence the high opening creditor balance.
Current creditors at 31st March 2016 included an HCA Loan of £5.9m which was repaid on 27th May 2016.

The Trust has increased long-term liabilities during 2016/17 to support its working capital requirements and to finance the Lorenzo PAS project.

Retained earnings forecast based on

Agenda Item: 10.1.2

TRUST BOARD MEETING (PART I) – 28 SEPTEMBER 2016

PERFORMANCE REPORT MONTH 5

PURPOSE	To update Trust Board on: • Progress against Monitor Compliance Framework, DH Operating Standards, Contractual standards and local performance measures. • Exception reports outlining action take and next steps are provided for indicators that are either 'red' in month, or at risk year to date.
PREVIOUSLY CONSIDERED BY	**FPC**
Objective(s) to which issue relates *	✓ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Delivery of financial, operational performance and strategic objectives, FT application, CQC ratings, Governance risk Rating, Contractual performance.
Healthcare/ National Policy (includes CQC/Monitor)	Achievement of Monitor, CQC, DH Operating Framework and other national and local performance standards.
CRR/Board Assurance Framework *	✓ **Corporate Risk Register** ✓ **BAF**
ACTION REQUIRED *	For approval ☐ For decision ☐ For discussion ✓ For information ☐
DIRECTOR:	CHIEF OPERATING OFFICER
PRESENTED BY:	CHIEF OPERATING OFFICER
AUTHOR:	SPECIAL PROJECTS MANAGER/DEPUTY DIRECTOR OF OPERATIONS
DATE:	SEPTEMBER 2016

We put our patients first We work as a team We value everybody We are open and honest
We strive for excellence and continuous improvement

* tick applicable box

PERFORMANCE REPORT

1. Key Headlines

The following table shows the trust's position against the 6 KPIs that have been agreed with the TDA, and are linked to the STF recovery trajectories.

STF KPIs

RTT - 52 week waits

	Apr	May	Jun	July	Aug	Commentary
Nat. standard	0	0	0	0	0	At time of writing validation had not been completed on 52 week waiters.
Forecast	4	4	4	6	6	
Actual	4	3	2	5	tbc	

RTT - Incompletes

	Apr	May	Jun	July	Aug	Commentary
Nat. standard	92.0%	92.0%	92.0%	92.0%	92.0%	Updated RTT recovery plan drafted, with the objective of getting to a sustainable position.
Forecast	92.0%	92.1%	92.4%	92.4%	92.5%	
Actual	92.7%	92.9%	92.6%	92.8%	92.5%	

A&E - 12 hour trolley waits

	Apr	May	Jun	July	Aug	Commentary
Nat. standard	0	0	0	0	0	On track.
Forecast	0	0	0	0	0	
Actual	1	0	0	0	0	

A&E - 4 hour waits

	Apr	May	Jun	July	Aug	Commentary
Nat. standard	95.0%	95.0%	95.0%	95.0%	95.0%	In line with trajectory, but has plateued at this level of performance.
Forecast	76.0%	77.0%	79.0%	81.0%	82.5%	
Actual	81.1%	84.7%	84.7%	84.2%	82.5%	

Cancer - 62 Day referral to treatment

	Apr	May	Jun	July	Aug	Commentary
Nat. standard	85.0%	85.0%	85.0%	85.0%	85.0%	Revised cancer action plan in place, with proposed trajectory for recovery.
Forecast	78.0%	81.0%	85.0%	85.0%		
Actual	80.5%	81.6%	75.0%	76.5%		

Diagnostics - Over 6 weeks waits

	Apr	May	Jun	July	Aug	Commentary
Nat. standard	99.5%	99.5%	99.5%	99.5%	99.5%	On track, despite increased demand.
Forecast	99.5%	99.5%	99.5%	99.5%	99.5%	
Actual	99.9%	99.7%	99.7%	99.7%	99.6%	

September '16 (STF) KPI Performance

Although the Trust did not achieve the ED 4 hour standard, (section 3) or the 62 day cancer standard, it did achieve the RTT standard, and the performance levels of the 6 KPIs that have been agreed with the TDA were all either met or exceeded in June, with the exception of 52 week waits that are still in the process of being validated. Stroke (4 hours) has been met for the first time.

2. RTT – 18 weeks

ENHT achieved the aggregated performance across the Open pathway standard in September at 92.5%, with the national position showing no discernible improvement in performance.

RTT Trust Aggregated Performance			
Month	Non Admitted (95%)	Admitted (90%)	Open Pathways (92%)
September 2015	91.9%	83.2%	93.0%
October 2015	91.6%	81.9%	92.7%
November 2015	90.4%	81.5%	92.6%
December 2015	90.6%	79.7%	92.0%
January 2016	89.3%	69.1%	92.6%
February 2016	91.3%	67.0%	92.6%
March 2016	91.9%	67.4%	92.0%
April 2016	91.3%	61.9%	92.7%
May 2016	92.8%	68.9%	92.9%
June 2016	92.2%	69.2%	92.6%
July 2016	89.8%	69.4%	92.8%
August 2016	90.6%	69.6%	92.5%

September '16 RTT Performance

2.1 RTT performance

ENHT has continued to achieve the national standard for open pathways, and is forecasting continued achievement in September, although the position looks vulnerable, and performance will again be close to 92%.

A detailed RTT recovery plan has been drafted and will be shared with NHSI. The actions included are a result of a combination of external reviews, and a trust-wide analysis of what is needed to stabilise the position, and deliver an improved and sustainable performance level.

2.2 Referral volumes

Referral levels remain higher than last year, although recent months have not seen a repeat of the 15%-16% increase compared to last year. Against plan broadly referrals remain higher, and seven specialties that are under (demand) pressure have been identified for further analysis.

2.3 52 week wait patients

As demonstrated by the metric in section 1, the trust continues to report low numbers of patients that have exceeded 52 weeks for their treatment. Whilst ENHT is by no means alone in this issue, this does not represent a high quality service for the patient; furthermore NHSI has a 'zero tolerance' to breaches of this standard.

Whilst ENHT has a good process for tracking patients to ensure they do not exceed this standard, there is an issue with patients being coded with an incorrect outcome. In these circumstance the patients 18 week RTT pathway is being incorrectly stopped and therefore the patient is removed from the PTL. When the error is subsequently identified the RTT pathway is corrected and therefore the patients are showing in many cases as having exceeded this standard.

To mitigate this issue a validation process has commenced that will require the validation of all the closed pathways in the last fifteen months. There is c, 70,000 records that will require validation, once this exercise has been completed then on going validation of RTT 'clock stops' will be required to ensure this situation does not reoccur.

The validation has required the redeployment of resource and will be undertaken over the remaining part of the current calendar year.

3. ED Performance

ENHT did not achieve the 4 hour standard in August, but did achieve 84.66%, which is higher than the STF improvement trajectory.

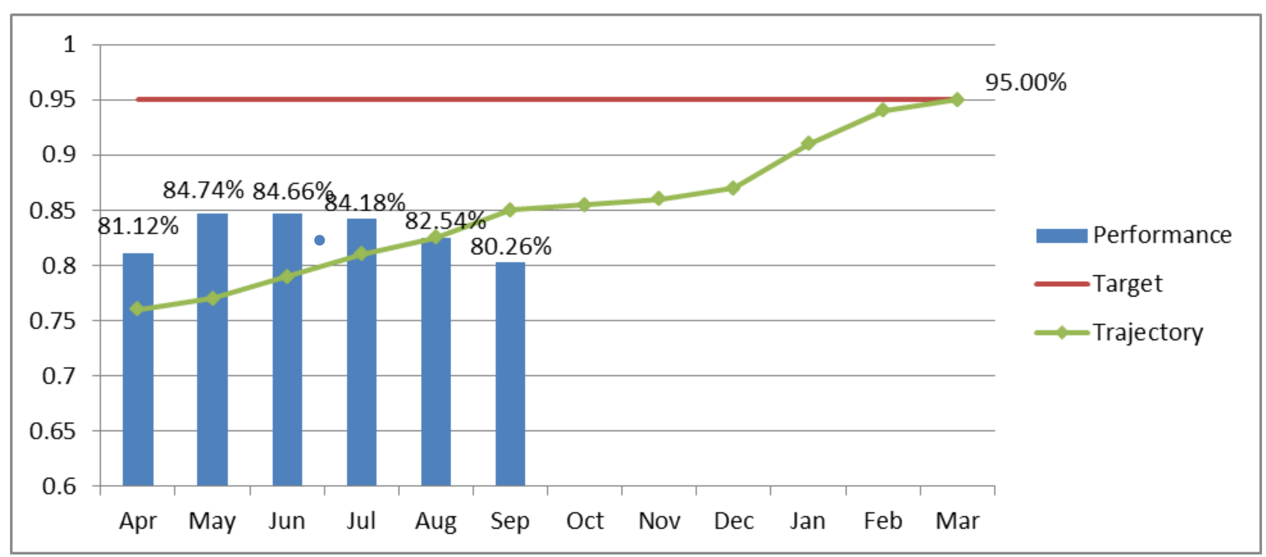
Month	% Performance	Quarterly Performance
Jul-15	91.02%	
Aug-15	87.84%	
Sep-15	85.93%	Q2 88.31%
Oct-15	84.38%	
Nov-15	77.82%	
Dec-15	80.50%	Q3 80.59%
Jan-16	80.45%	
Feb-16	76.28%	
Mar-16	75.53%	Q4 77.33%
Apr-16	81.12%	
May-16	84.70%	
Jun-16	84.66%	Q1 83.58%
July-16	84.18%	
Aug-16	82.54%	Q2 83.40%

August '16 ED performance against 4 hour standard.

Department	Apr-16		May-16		Jun-16		Jul-16		Aug-16	
	Attendances	Admitted	Attendances	Admitted	Attendances	Admitted	Attendances	Admitted	Attendances	Admitted
Majors	4166	1908	4550	2158	4457	2108	4613	2248	4422	2077
Minors	4225	226	5154	243	4559	220	5207	238	4656	257
Resus	545	433	628	498	593	454	655	530	600	476
Triage	323	85	342	126	347	144	330	96	259	97
Primary Care	2347	110	2461	115	2327	111	2637	130	2275	100
Streaming									1	0
Others	671	0	699	0	730	0	677	4	634	2
Total	12277	2762	13834	3140	13013	3037	14119	3246	12847	3009

Year to date ED attendance and admission figures

The system-wide 4 hour recovery trajectory, as below:



September '16 - 4 hour performance trajectory

ED performance is unlikely to achieve the STF trajectory in September given the current in month position. The clinical team from ECIP have confirmed their attendance for the 30th September with a view to assisting us with reviewing some of the clinical pathways. In addition ENHT is launching a pilot of the 'Red

and Green days' programme, week commencing 26th September on six wards, with a view to rolling out to a second and third cohort every two week. The 'Red and Green days' programme has been successfully implemented in other organisations and has made significant improvements to patient flow and the trust performance against the 95% standard.

Colchester Hospital, who had significant performance issues related to the 95% standard, has recently made significant improvements in their performance which their COO believes is primarily related to the implementation of this programme.

The programme has a very simple methodology, each patient is expected to have a clearly stated next step in their treatment plan that relates to the patients EDD (estimated date of discharge). If the patient does not have a clear next step or the action remains outstanding for a maximum of 14 hours then that is considered a 'red' day for the patient and of limited value to their treatment.

Once a 'red' day has been identified urgent escalation is implemented to unblock or remedy that situation. The escalation keeps progressing that day and can ultimately involve the CEO if required. This programme aims to reset the organisations tolerance to delays in the patients pathway which in turns increases flow and releases capacity, whilst providing a quality service to the patient.

4. Cancer

Cancer performance is reported retrospectively, July's finalised position is shown below.

Cancer Flash Report

Performance July 2016

Target	Goal	Threshold	Month To Date	Quarter To Date	Year To Date	Nat Average (April)	Nat Average Qtr (Q4)
Target Referrals							
Cancer Referral to 1st Outpatient Appointment	< 14 Days	93.0%	96.7% ▼	96.7% ▼	97.4% ▲	94.4%	93.7%
Referrals with Breast Symptoms (wef January 2010)	< 14 Days	93.0%	88.8% ▼	88.8% ▼	93.1% ▼	92.1%	91.9%
Cancer Treatments							
Decision to Treat to 1st Definitive Treatment for all Cancers	< 31 Days	96.0%	97.8% ▲	97.8% ▲	95.7% ▼	97.8%	96.8%
Referral to Treatment from Screening (62 Day)	< 62 Days	90.0%	92.9% ▲	92.9% ▲	88.7% ▼	92.3%	91.3%
Second or Subsequent Treatment (Anti Cancer Drug Treatments)	< 31 Days	98.0%	97.3% ▼	97.3% ▼	97.6% ▼	99.4%	99.4%
Second or subsequent treatment (Radiotherapy Treatments)	< 31 Days	94.0%	93.1% ▲	93.1% ▲	92.8% ▼	97.4%	97.2%
Second or subsequent treatment (Surgery)	< 31 Days	94.0%	94.9% ▼	94.9% ▼	96.3% ▼	96.0%	95.3%
Urgent Referral to Treatment of All Cancers	< 62 Days	85.0%	76.5% ▲	76.5% ▼	77.8% ▲	82.0%	82.2%

July '16 (Unadjusted) Cancer performance

4.1 Performance

- A comprehensive action plan has been resubmitted to NHSI, following agreement with the CCG.
- Monitoring of this will be an integral to the delivery of the plan as it is pan divisional.
- New PTL weekly meetings commence next week after a trial for Urology Tumour site over the last 2 weeks.
- Strategic Cancer Network completed their review of our service on 14th Sept; on the day feedback was positive with strong clinical engagement. We are awaiting their draft report, expected in the next two weeks

4.2 Breast Symptoms

The trust did not achieve the 2 week wait standard for breast symptoms patients in July. One patient failed the standard, however because the dominator was very low (n.7), a single breach will result in the non-

achievement of this standard. ENHT are forecasting achievement in August however because of the small denominator there is an ongoing risk.

5. Stroke

Stroke Performance for August 2016. Is shown below:

Metrics	Oct '15	Nov '15	Dec '15	Jan '16	Feb '16	Mar '16	Apr '16	May '16	June'16	July'16	Aug'16
Stroke Discharged with AF on anticoagulants (ASI 1)	83.3%	80%	87.5%	66.7%	50%	100%	66.7%	100%	84.6%	86.7%	83.3%
Stroke – 4 hours direct to stroke unit (ASI 2)	48.9%	62.5%	69.4%	59.6%	61.8%	68.1%	71.2%	85%	84.8%	77.8%	91%
Stroke – 90% of time on the stroke unit (ASI 3)	89.6%	86%	75%	87%	71.4%	88.6%	91.2%	93.7%	88.6%	74.3%	91%
Stroke – 60 min to scan 9ASI 4a)	40%	50%	50.9%	40%	48.3%	50.7%	42.6%	65%	55.1%	60%	58.8%
Stroke 60 mins to scan urgent only	87.5%	96%	91.7%	82.6%	84.4%	93.9%	96%	96.7%	100%	91.1%	89.5%
Stroke – scanned within 24 hrs (ASI 4b)	97.9%	98%	96.2%	96.4%	98.4%	100%	100%	96.7%	100%	98.6%	100%
Stroke thrombolysed within 3hrs	0%	7%	12.5%	7.7%	5.2%	6.2%	3.2%	5.5%	4.6%	4.6%	3.3%
Stroke – discharged with JCP (ASI 7)	93.5%	96.9%	100%	100%	89.5%	96%	98%	97.4%	87.8%	97.3%	92.3%
Stroke –discharged with ESD (ASI 9B)	36.1%	36.8%	38.1%	35.7%	40%	40.7%	39.6%	23.3%	43.5%	37.5%	31.1%
TIA – high risk, not admitted, tx within 24hrs	85%	69.6%	48.4%	75.9%	69.2%	66.7%	51.3%	70.8%	83.9%	68%	63.3%
TIA – high risk tx within 24hrs	85%	69.6%	51.5%	75.9%	69.2%	66.7%	50%	68%	83.9%	68%	63.3%
TIA – low risk, treated within 7 days from first contact	88.2%	82.9%	73%	88.1%	94.7%	83.8%	91.9%	89.1%	80.4%	66.7%	88.9%
TIA – low risk, treated within 7 days from onset	47.1%	53.7%	45.9%	59.5%	63.2%	54.1%	59.5%	58.7%	42.9%	44.4%	48.1%

August '16 Stroke performance

5.1 4 hours direct admission to a stroke unit

91% delivered for 4hrs in August with 67 confirmed strokes. This is the first time the stroke unit has achieved the 4hr target.

Actions to sustain performance:

- Ensure stroke nurses have rights for requesting CT's. Delays in the Emergency department resulting in patients receiving CT's outside of the one hour timeframe, especially for those who are fast –ve.
- Further teaching required with the ED team's in terms of identifying stroke patients
- Agreement to be sought for a form of prioritisation of stroke patients out of hours
- Continue to review the bed capacity requirements for stroke.
- Potential to increase bed capacity on existing stroke unit during peak demand.

Risks to future performance:
Delays in patents being reviewed in the ED, the current delays results in breaches of the standard, especially out of hours

Lack of ESD service in Bedford – is increasing length of stay on the stroke unit.

5.2 Thrombolysis within 3 hours

3.3% of patients in August were thrombolysed

Thrombolysed overall – 6.6%

Risk to Thrombolysis: patients coming from further afield i.e. West Essex arriving outside the therapeutic window for treatment.

Actions to improve Thrombolysis:

A thrombolysis audit is currently under way. Following this we expect to take informed actions for improvement.

Further public engagement and advertising to encourage earlier presentation of patients – pre hospital care

** End of document **

Agenda Item: 10.1.3

TRUST BOARD MEETING (PART I) – 28 SEPTEMBER 2016

WORKFORCE REPORT MONTH 5

PURPOSE	To provide information on standard monthly metrics and Trust wide issues relating to management of the workforce
PREVIOUSLY CONSIDERED BY	**Finance and Performance Committee**
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☑ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Financial: increased workforce costs HR: failure to meet agreed standards Legal: failure to meet CQC and other national standards Patient Safety: failure to maintain appropriately trained workforce
Healthcare/ National Policy (includes CQC/Monitor)	CQC 13 and 14 NHSLA
CRR/Board Assurance Framework *	☑ **Corporate Risk Register** ☐ **BAF**
ACTION REQUIRED *	For approval ☐ For decision ☐ For discussion ☑ For information ☐
DIRECTOR:	Director of Workforce and Organisational Development
PRESENTED BY:	Director of Workforce and Organisational Development
AUTHOR:	Head of Workforce Performance, Information & Planning
DATE:	September 2016

We put our patients first We work as a team We value everybody We are open and honest
We strive for excellence and continuous improvement

* tick applicable box

Workforce Report September 2016

1.0 Purpose

This paper provides an update to Trust Board for September 2016 on workforce performance.

2.0 Our Culture – Ambition

We want to be known as an organisation where our people feel engaged, valued and supported and empowered to deliver excellent patient care and services they are proud of.

2.1 Culture Programme

Strategy: The Culture Programme aims to improve staff engagement so that we are amongst the top 20% of acute hospital Trusts within three years. This will be achieved by embedding a strong leadership culture, leading to improved patient and staff experience and improved customer satisfaction with our services; this will lead to sustained improvements in services.

Actions: The Leadership and Management Development Pathway (LMDP) was launched in August and courses begin in September. The programme builds on existing interventions as well as creating new and contextual appropriate content. The capacity to train our own staff has doubled and the programme has been designed to continual adapt and grow. A senior set of programmes will be designed over the coming months and the SLMDP (Senior Leadership and Management Development Pathway) will be launched later in the year.

Phase 2, first 100 coaching programme concludes over the next few weeks and Phase 3 commences in which a further 200 staff will receive training. More of this phase will be conducted by ENH staff and it is envisaged that the course establishes itself as a continuing programme. Further work on the role of coaching and coaching as an approach to leadership will be undertaken in the Autumn.

The last set of ARC sessions were the last. ARC was a successful collection of interventions and initiatives and many of these now stand on their own. A new overarching theme will emerge driven by Listen Empower Nurture Develop (LEND).

National Staff Survey: Preparations for the 2016 national staff survey are being finalised. The survey will launch on 3 October and all staff will be surveyed.

Local services, supported by HRBP, are developing and adapting the appraisal documentation in order to improve compliance. In the current financial year, two revised and shortened versions of the appraisal forms were launched in Divisions of cancer services, and medicine. Monthly quality and consistency audits continue, with collaboration of HRBPs, and these indicate an improvement in the overall quality of performance reviews. Continually improving the process is being followed up by the appraisal training lead, including feedback to appraising managers. Observed appraisals are undertaken and these have proved useful in further improving the quality and consistency of the process. 150 places have been offered for training in the current financial year, including two additional sessions in December to meet demand. To date 64 managers have attended the training, and their feedback in relation to effectiveness and content of the training achieved a scored 4.6 out of maximum of 5.

Performance: Increased focus on the development of leadership with the aim to see more of the organisation seeing themselves as leaders and culture creators. Coaching will be a

significant leadership and management style deployed within the organisation. The Board have given OD time and space to constantly develop and evolve the notion of LEND. The approach was launched and feedback received at the final set of ARC sessions and it is now present in all LMDP courses. Evaluations, assessment and continual evolution will be undertaken in the Autumn.

Staff Friends & Family Test: The Trust's Quarter 1 Staff FFT results were the best since the test commenced in April 2013 and also show a marked improvement compared to the national acute Trust average, which was published in late August. The Trust is now in the third quartile for both *Recommend for care* with a score of 79% compared to an acute Trust average of 82%, and for *Recommend for work*, with a score of 61% compared to an acute Trust average of 66%. Section 2, Graph 1, FFT Trend Graph.

2.2 Health at Work

Strategy: To achieve the staff health and wellbeing CQUIN goal for 2016/2017, to improve the support available for staff to help promote their health and wellbeing in order for them to remain healthy and well. The Health at Work service are working in partnership with other key services to develop initiatives and process pathways to enhance workplace health and wellbeing.

Actions: Positive feedback has been received from the CCG following the submission of the staff health and wellbeing CQUIN plan on the 1st July. A staff wellbeing survey has been completed with 193 responses. This has provided valuable information about the physical activities, mental wellbeing initiatives and healthier food options staff would like to be available at work.

New staff health and wellbeing initiatives have been undertaken. Eat Well at Work Day was held on 14 June, and One You Day on the 7 July. A meeting was held with Workplace Options the Trust's Employee Assistance Programme on 27 June to expand current services provided within the Trust contract for EAP services. A 'Know your numbers' day is planned for the 20th September.

This year's staff flu vaccination campaign is being planned. Flu champions are being requested, all managers have been asked to identify suitable dates, times and locations for their teams to have local drop in clinics. The Health at Work team will be visiting clinical areas the first week of September to promote the campaign, distribute information and talk to staff about how we can make the vaccine as easily available as possible.

Performance:

July - The Health at Work Service received and processed 202/239 (84.5%) pre-placement health clearances within 2 working days and worked in partnership with Medical Personnel on the new doctor recruitment for August. 68 manager referrals were received of which 3 were incomplete. 37/65 (56.9%%) were booked within agreed delivery times. Following attendance in clinic 44/45 (97.7%) reports were issued within the 2 day target delivery time.

August - The Health at Work Service received and processed 148/167 pre-placement health clearances within 2 working days. 89 manager referrals were received of which 3 were incomplete. 82/86 (95.3%) were booked within agreed delivery times. Following attendance in clinic 74/82 (90%) reports were issued within the 2 day target delivery time. Section 2, Table 1, Health at Work Service core activity.

3.0 Developing our people

Ambition: We want to develop our people so that everyone has the skills and knowledge they need to deliver high quality patient care and so that we can build our workforce for the future.

3.1 Appraisal rate

Strategy: That all Trust staff have an annual appraisal that sets clear objectives, recognises achievement and agrees development goals, the Trust target is 85% compliance.

Action: Divisional Director leadership teams are personally overseeing the approval process of switching off automatic pay progression for staff who have not received an appraisal and are fully statutory / mandatory training compliant; this has also been effective for managers who supervise staff and for all staff.

Performance: The overall appraisal rate for the Trust was 81.28% in August compared to 79.79% in July and 79.11% in June (12 month rolling); see Appendix 1, Section 3, Table 1. The appraisal rates over a rolling 12-month period were highest in CSS (91.74%). Compliance within surgery is 80.38%. Medicine division compliance is 68.3%. As approximately a third of all staff appraisals are due in September and October, the current appraisal rate is likely to remain reasonably static until November, after which the rate is expected to increase significantly to approximately 85%. See Section 3, tables 1 & 2.

3.2 Statutory and Mandatory Training

Details of statutory and mandatory training data can be found in Appendix 1, Section 3, Table 3.

4.0 People Performance

Ambition: We want to ensure that we have the people we need and are clear about the standards we expect. This will enable and support the delivery of safe, consistent and high quality patient care.

4.1 Vacancy Rates

Strategy: To reduce the vacancy rate to 5% by February 2017 in order to support the trust's People Strategy and the Safer Staffing agenda. The achievement of the said strategy is reliant on new, innovative attraction, recruitment and retention projects.

Action: Having designed and implemented new recruitment initiatives, the Trust has been committed to improve its vacancy rate to a level, which will allow reducing reliance on temporary staffing usage. As a consequence, it is expected that the temporary staffing pay bill will reduce in line with the recruitment trajectory.

The Trust has recently started new recruitment campaign which main aim has been to encourage people from the neighbouring counties to travel less and join the East and North Herts as an organisation of choice. As a result, large scale campaign has been launched on 22nd August (the campaign included: advertising on: Heart FM, social media, trust's recruitment website, bus shelters and buses as well as train stations)

Previously agreed actions and projects are still underway and the summary of those can be found below:

- Carry on with the UK recruitment
- Target UK student nurses and newly qualified nurses
- Increase Filipino campaigns
- Commence India recruitment

- Continue sourcing nurses from within the EU
- Consider alternative overseas labour markets
- Consider alternative pension options to band 5 and 6 nursing staff – this project is due to launch on 12th September 2016
- Increase the CSW recruitment episodes due to the increased establishment

A detailed vacancy trajectory taking into account a set of assumptions and estimates is presented in the appendix 2 of this report.

Performance: The baseline vacancy rate is at 8.98% in August compared to 8.81% in July and 9.20% in June.

There is an additional 174 wte (3.7%) staff in post compared to August 15. However, the qualified nurse levels have returned to the same level as August 15. Since April, an addition 31 wte staff recruited to the trust compared to plan, however the trust had 96 wte more leavers than anticipated. For Band 5 Nurses, 35 wte less than plan have started and 4 wte more left than plan, this is proving challenging operationally. A detailed breakdown is given in appendix 2.

There were 244 wte added to the establishment in April. The increase in establishment adds over 4% to the vacancy level. The vacancy level based on the new establishment is currently 13.23%.

There are currently 325 wte external candidates undergoing cohort recruitment, pre-employment checks and awaiting start date of which 217 wte are qualified nurses. The target of achieving the vacancy rate of 6% in has moved to May rather than February due to the recent increase in establishment.

Appendix 1, Section 4, Table 5 provides benchmarking data across Bedfordshire and Hertfordshire NHS Organisations and details Vacancy, Turnover and Agency costs comparisons in Quarter 4.

4.2 Resourcing Performance

Strategy: To be quicker than our competitors in converting offers of employment into commencement of work in the Trust. To ensure we fulfil all governance requirements to safely recruit staff and provide excellence in customer service

Action: Whilst the Trust is preparing to fully implement the 'Streamlining Recruitment Processes' project, a number of initiative have been taking place within the Resourcing Team to reduce time to hire, whilst maintaining full compliance with the trust policies and processes relating to recruitment. A deep dive recruitment process review which has been initiated in June 2016 is under way and a number of stages of the process are being aligned with the East of England 'Streamlining' project. This includes review and redesign current practices and development of new standard operating procedures, which will support the strategy. The action plan to improve further the time to hire and the compliance with regulatory bodies' requirements includes regular training and refresher training sessions for the resourcing administrators. These include all stages of the recruitment process as guided by the NHS Employers.

A robust process of reporting, monitoring and addressing any potential issues and training needs is in place. Monthly GAP analysis report is shared with Resourcing Administrators as well as the Director of Workforce and OD to ensure the highest quality of pre-employment checks have been undertaken for all new employees joining the trust as well as existing employees moving departments.

Performance: The monthly GAP analysis results have been steadily increasing month on month. For the months of July and August the initial results oscillated in the region of 98% and 99% respectively.

Time to hire has fluctuated over the summer months with a slight reduction in July and an increase in August 2016. The overall time to hire has increased slightly in August compared to June and July 2016 and is 2 days beyond the 9 week target. This is due to a significant increase of the number of candidates undergoing pre-employment checks and awaiting start date. In August 2016, the recruitment pipeline has consisted of an excess of 450 applicants. 92 new employees started working for the trust in August 2016 and it is anticipated that a considerable number of new staff will join the trust in September and October 2016 (this is to include student nurses and midwives as well as overseas staff).

It is important to mention that in order to support the Trust's agenda to reduce vacancy rate, number of new initiatives have been initiated in the summer. The trust has also become a direct employer of Filipino nurses and has recently signed contracts with 4 direct agencies. The trust is only a third known NHS organisation that has achieved this.

4.3 Temporary Staffing

Strategy: To reduce agency pay costs and unit pricing through the Trust control environment and the management of agency suppliers. To improve the efficiency and performance of the temporary staffing service ensuring that processes, policies and guidelines are adhered to for the optimal delivery of the temporary staffing service and financial control. To build a clear demand model aligned to the permanent recruitment plan to give greater certainty and visibility around agency and bank costs.

Action: An Agency Reduction Committee has been formed to focus on the development and implementation of strategies to reduce agency usage in the Trust. Following recommendations from the committee a number of key initiatives have been introduced. An agency approval mechanism has been added to the General Nursing cascade to ensure only shifts that are essential to be filled without any other method of mitigation are released to Tier 2 and 3 agencies. Full agency restriction has been added to the Care Support Worker cascade so that shifts are only released to bank. Twice daily scrutiny of unfilled shifts takes place to plan ways of mitigating shortfall without use of agency. A new agency long line approval process is being piloted across four wards with the objective of switching off direct agency booking. The current agency long line placements will be targeted for bank fill. This process will be rolled out across all wards in structured stages.

The 'Love the NHS' initiative continues across the Trust and has seen increasing numbers of workers joining the bank. The bank offering is being developed further to ensure it is an attractive proposition by providing learning and development opportunities to support revalidation. New information sheets describing the bank offering have been circulated to all managers in the Trust to support with the message to workers.

The number of staff coming through on the Care Support Worker Development program has been increased. Workers identified with care skills and trust values, wanting to working in the NHS, are recruited through the bank and trained on the wards. In addition, existing bank staff are being trained to develop skills to work as part of a peripatetic team to care for patients who require close observations.

Effective 1st July NHSI introduced Wage Rate caps and the Trust are now also required to report any breaches weekly. Work is ongoing to ensure data received on agency rate cards enables us to report a correct position. The regional Critical Care cascade for nursing has been reviewed and current shortfall of staff in A&E and Paediatrics meant that there has been no further reductions in pay rates due to poor fill rates. All Theatre Managers from the

Trusts in the Cluster met to formalise agreements for rates and booking process across the cluster. This group will continue to meet on a regular basis to progress the cost reduction plan. Action plans are also being drafted to reduce the number of breaches in the remaining specialist areas.

The doctors' service transformation project continues to progress. The new medical booking platform has been developed with further functionality including reporting capability. NHSP are producing new marketing material to promote the service and various offerings are being considered as part of the medical locum migration strategy to increase bank medical fill. Three Medical Roster Co-ordinators have been recruited one each for ED, Medicine and Surgery and will be starting in the Trust on 5th September. These roles will support the promotion and processes as part of the transformation project.

The temporary staffing and finance teams have been carrying out a market testing exercise for the set up a direct engagement model. A number of providers have presented their service offering to the Trust and further enquiries in the benefits of the various types of models have taken place. It is predicted that savings would be in the region of £1m p.a. A paper has been prepared and is to be presented to executives in September.

Performance: Through implementation of agency price caps, agency unit cost continues to fall. Qualified nursing reduced by £0.29 per hour, Doctors and other clinical remained the same. Despite an increase in shift requests (165) for nursing and midwifery agency shifts reduced by 16% (691 shifts). This has meant that agency cost has reduced by £67k. However, unfilled rates increased by 10%. This has had an impact on the ability to maintain appropriate levels of cover for the wards, particularly for day shifts, which needs to be addressed with bank fill for September. There was a slight increase in agency medical staff (36 shifts) largely relating to shortfalls in ED. Agency expenditure reduced by £230k however this is mainly due to overstating spend in previous months. Non Clinical agency increase by £40k due to usage in Corporate Services. Retrospective bookings over two weeks increased compared to the previous month and is now breaching the target position. Retrospective booking data will now be reviewed as part of monthly PMO schedule by Trust Executives. Appendix 1, Section 4, Table 6.

4.4 Turnover

Strategy: Employee turnover affects the performance and structure of the Trust. When an employee leaves, we lose training, information and knowledge. However, turnover can also bring new skills and experience. The goal is to have an optimal rate of turnover at a sustainable level, for this Trust this been assessed at between 10 - 11%.

Action: Turnover data has been provided at a division, directorate and staff group level so that action can be taken to assess and address areas of high turnover. Exit questionnaires and interviews have been conducted with those leaving the Trust to help divisions identify themes. The Trust has identified a number of retention initiatives that require funding and these are currently being assessed by the Investment and Scrutiny Committee.

Performance: The Trust's turnover decreased to 12.77% and 12.51% respectively in July & August compared to 12.88% in June. 235 wte staff started in August compared to 217 wte leavers (including M&D staff). Since April 16, 554 staff have started the Trust and 488 have left. 14.01 wte qualified nursing staff started in August compared to 21.64 wte qualified nurse leavers. Appendix 1, Section 3, Graph 1 details the starters and leavers trend over the last year.

4.5 Medical Staffing

4.5.1 New national contracts proposed for Junior Doctors

Strategy: To manage the successful and timely implementation of the new national contract for junior doctors. To maintain positive relationships with the medical workforce during this period of proposed further industrial action and anticipated contract implementation from December 2016 to safeguard patient care.

Action: The national pause on new contract activities continued through to the outcome of the BMA referendum on the 5 July 2016. The go ahead was given to send first placement offers on the old 2002 contract terms to the imminent August 2016 intake and revised offer letters were sent accordingly. The Secretary of State announced that the implementation of the new 2016 contract (May 2016 ACAS facilitated version) would proceed starting from October 2016 despite the negative outcome of the BMA referendum.

During the pause both NHS Improvement and the BMA endorsed for Trusts to proceed with the appointment of the Guardian of Safe Working Hours role. The trust has successfully appointed Dr Stephen Bates, Consultant Anaesthetist who commenced in role on the 26 July 2016.

A Junior Doctor Contract Project Group was set up in June and meets fortnightly. Members currently include the Guardian of Safe Working Hours, Director of Medical Education as well as BMA, Finance, HR and Postgraduate Medical Education representation. Work Schedules for the F1s and F2 sharing a rota with F2 doctors are currently in draft format.

Work is being undertaken in collaboration with the Governance team in relation to fulfilling the local requirements for the public sector equality duties under the Equality Act ahead of the contract being introduced in the Trust in December 2016. 14 out of a total of 35 rotas have been adjusted for August 2016 to be mixed economy rotas (accommodating 2002 and 2016 terms) in preparation for the forthcoming phased transition points. Preparations commenced for managing further Industrial Action by the junior doctors in anticipation of possible Industrial Action being announced by the BMA after the Council meeting on the 31 August 2016.

Performance: Information and templates for offers were supplied to the Medical Resourcing team swiftly after the go ahead to proceed with first placement offers. The Guardian appointment on the 27 June was well within the deadline to appoint a Guardian by the 26 July. The project group continues to meet and membership has evolved as required and the group continues to proceed with actions on contract matters. 14 out of the 15 planned rota changes for August 2016 took place with a revised timetable now agreed for the 15th rota which is still within an acceptable timeframe. A contingency planning meeting was set up in collaboration with Operations to coincide with the BMA Council announcement for the possibility of being given 7 days' notice of commencement of a full walk out.

4.6 Employee Relations

Strategy: The aim of the Employee Relations Advisory Service (ERAS) is to deliver a customer service focused ER function, providing both managers and staff with advice and support on all Employee Relations issues, eradicating bullying and harassment.

Action: The ERAS team has introduced a number of measures to support both managers and staff. These include immediate responses to queries, the implementation of the anonymous raising concerns platform (Speak in Confidence) and the bullying and harassment survey that has been undertaken by Duncan Lewis.

ERAS has implemented a number of training programmes for managers, these include; Absence management, Disciplinary, Emotional Intelligence, Difficult conversations, Bullying and Harassment, Raising concerns and Performance management

Performance: In August, the percentage of employee relations cases within the Trust was 3.0% and within the target range. The overall number of live employee relations cases decreased from 214 to145. The high number of cases is mainly due to the work the ERAS team is undertaking to record sickness cases which have been identified in departments.

The customer feedback score in August for the ERAS service was 2.8 (measured on a scale of 1 to 3 with 3 being excellent). A detailed table showing the ERAS performance in all employee relations areas can be found in Appendix 1, Section 4, Table 7.

Exit Interview Data: From the 39 exit interviews that were undertaken in August, enhanced job opportunity was cited by 23% of leavers. 15% stated that they were relocating. 15% cited family/personal reasons, 13% retirement and 13% further education.

A detailed table showing the Exit Interview Data can be found in Appendix 1, Section 4, Table 8 including qualitative data from leaver's responses.

4.7 Disciplinary Cases

Strategy: The aim of the ERAS team is that all disciplinary cases are effectively managed and resolved within 90 days of the case being opened.

Action: ERAS has trained over 400 managers on disciplinary processes since June 2015. ERAS has developed new training programmes for 2016 to help managers deal with disciplinary procedures. A review of the current disciplinary policy is underway. The proposed new policy will enable a quicker approach to concluding disciplinary cases.

Performance: The benchmark across five NHS organizations for the percentage of disciplinary cases of headcount is between 0.5% and 1.0%. In August, the Trust percentage was 0.2% and within the target range.

The Trust's Key Performance Indicator is to complete all disciplinary cases within 90 days. Priority has been given to support the management of disciplinary cases that have been open for a considerable amount of time. Out of the 12 live cases in August, 3 were over the Trust's KPI of 90 days. These cases have been identified and are under management with ERAS support to ensure completion without further delay

4.8 Sickness Absence

Strategy: To reduce sickness absence below 3.5% by August 2017. The approach to achieving this is by providing advice and support to both managers and employees to optimise health at work, reduce sickness absence and prevent work related ill health and injury therefore reducing the cost of sickness absence across the Trust.

Action: Workforce and OD have implemented both Absence Assist and the ERAS team to support with the management of sickness absence as well as the Health at Work service.

Performance: The Trust annual sickness absence rate decreased to 3.61 % in July and August compared to 3.65% in July. In month, sickness saw an increase to 4.37% in August from 4.06 % in July and 3.96% in June. Long term in month sickness increased to 2.39% in August from 1.87% in July and 2.01% in June. The number of staff on long term sick has increased to 112 in August compared to 89 in July and 96 in June. Currently long term sickness cases (including under monitoring cases) are being managed through the HR Advisory Service. A review of all long term sickness cases continues to be undertaken.

Short-term sickness in month decreased to 1.99% in August compared to 2.18% in July and 1.96% in June. The number of days lost to sickness in August was 6482 compared to 6027 in July and 5663 in June.

The sickness rate for nursing and midwifery is higher than the Trust average with an overall rate of 5.7%, which was 3619 days lost and has driven agency expenditure in ward areas. Further work has been carried out in ward areas to ensure effective sickness management and the value of having a centralised model of sickness absence reporting is currently being explored. See Appendix 1, Section 1, Graph 1, Sickness Absence.

4.9 HR Policies and Procedures

Strategy: To review policies in line with the planned policy review date, so that policies are updated in a timely fashion.

Action: A more streamlined approach to policy review is currently being undertaken.

This approach is line with the report completed by Lord Carter detailing that NHS Trusts need to create an environment that is fair and transparent. NHS Employers have also produced examples of shorter succinct policies that are user friendly to managers and staff. Therefore, we need to ensure that our HR policies are clear and simple. The new format for policies has been sent to the Unions and we are awaiting their comments.

Performance: A timetable for future policies has been defined and the following policies have been extended to allow for additional time due to implement the new approach to policy review.

4.10 Governance

Strategy: To ensure the Workforce and OD team achieves compliance with governance requirements and reviews processes where appropriate.

Action: In order to support the flexible working project, we are updating the contract documentation for staff wishing to work annualised hours or term-time contracts.

In order to support the Resourcing team's application to the UKVI for a renewal of our visa sponsorship licence, we plan to audit staff files to check the appropriate right to work documentation is available. We are working with the ERAS team to review latest guidance from the Department of Health on records retention, to develop new Standard Operating Procedures for retention of employee relations records. The governance team is working with the Medical Staffing HR Business Partners to undertake the local equality analysis required in relation to implementation of the new 2016 contract for doctors in training.

Performance: The ESR gap analysis report for June starters recorded 98% compliance for the first run and 99% compliance in the final run. July starters compliance levels were 97.5% for the first run and 98.5% for the second run.

Agenda Item: 11.1

TRUST BOARD MEETING – 28 SEPTEMBER 2016
RISK AND QUALITY COMMITTEE – 20 SEPTEMBER 2016
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Trust Board the report from the Risk & Quality Committee (RAQC) meeting of 20 September 2016.
PREVIOUSLY CONSIDERED BY	N/A
Objective(s) to which issue relates *	[X] 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. [X] 2. **Developing new services and ways of working** – delivered through working with our partner organisations [ ] **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key assurance committee reporting to the Board. Any major financial implications of matters considered by the RAQC are always referred to the FPC.
Healthcare/ National Policy (includes CQC/Monitor)	In line with Standing Orders and best practice in corporate governance.
CRR/Board Assurance Framework *	[ ] **Corporate Risk Register** [X] **BAF**

ACTION REQUIRED *

For approval	[ ]	For decision	[ ]
For discussion	[X]	For information	[ ]

DIRECTOR:	Chair of RAQC
PRESENTED BY:	Chair of RAQC
AUTHOR:	Corporate Governance Officer / Company Secretary
DATE:	September 2016

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We strive for excellence and continuous improvement

* tick applicable box

RISK AND QUALITY COMMITTEE – MEETING HELD ON 20 SEPTEMBER 2016

SUMMARY REPORT TO BOARD – 28 SEPTEMBER 2016

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

The following Executive Directors were present:
Bernie Bluhm and Jane McCue

Outcomes:

Divisional Presentation – Children's

The Divisional Chair for Children's Services and the Children's Nursing Services Manager delivered a presentation regarding Children's services at the Trust. The presentation gave an overview of the service, detailed the service's top risks and mitigations as well as looking at key challenges and future developments. The service's ratings from the October 2015 CQC inspection included some good and outstanding areas as well as some areas requiring improvement, and a number of actions had been taken to address the concerns raised in the CQC inspection. The findings of a follow up unannounced inspection by the CQC in May 2016 had acknowledged that progress had been made. It was noted that there had been no SI's or IRI's in the past 12 months across the Children's service. The number and themes of both complaints and incidents regarding Children's services remained broadly consistent. The Committee discussed and noted the service's top risks. Key challenges for the service included medical and nursing recruitment, retention and development and support for 7 day services. The Committee also discussed Safeguarding Children Level 3 training compliance. Work was underway to increase the level of compliance within the division as well as to consider ways to improve provision of the training for the Trust as a whole. The Committee considered that the presentation provided a good degree of assurance regarding the service.

Emergency Pathway Project and plans to improve the A&E 4 hour target

The Interim Chief Operating Officer provided an update regarding the Emergency Pathway Project and plans to improve the A&E 4 hour target. The Committee were informed that the Project had been reviewed and updated and there was now a greater emphasis on ensuring that actions were delivered as soon as possible, in order to assist with delivery of the Trust's A&E 4 hour target recovery trajectory. The Committee discussed the factors which were considered to be impacting on the Trust's performance, a significant element being an increase in demand. The Committee received the update and supported the actions being taken to ensure more focus is placed on agreed milestones being delivered.

Floodlight Scorecard / Exception Reports

The Committee considered the latest version of the Floodlight Scorecard. It was noted that the report included some indicators which were yet to be validated. Performance against the RTT target was at 92.5% for August 2016. The Committee were informed that a comprehensive action plan had been developed regarding performance against the cancer targets. It was noted that 52 week breaches were currently being reviewed and validated, which would be reflected in the levels reported for August and September and the outcome of the review would be presented at the next RAQC. There was discussion regarding the stroke service and the impact on the Trust of changes to stroke provision elsewhere. The Committee also discussed the KPI regarding the percentage of stroke patients thrombolysed within 3 hours which remains low. The Committee was advised that a reason for this is the number of patients presenting to the Trust within the appropriate timescale. It was considered therefore that an additional KPI which provided the percentage of patients

thrombolysed within 3 hours where appropriate to do so and where the patient had presented within the necessary timeframe would be beneficial.

Serious Incident Report

The Trust had reported 6 Serious Incidents (SIs) in July and 5 SIs in August. None of the SIs across the two months were as a result of hospital acquired pressure ulcers. It was reported that delays to diagnosis were a common theme amongst the SIs declared in the year to date, and work was in progress to improve this. Fewer SIs had been declared in the year to date compared with both 2015 and 2016, in part due to changes in the requirements regarding the reporting of pressure ulcers. It was agreed that future reports would include a more detailed breakdown of the themes of SIs in the year to date. The Committee noted the report.

Medical Director Report

The Committee received the Medical Director's report. The report detailed the work which was progressing towards meeting the standards set out within the Medicines Optimisation Framework. The Committee were notified of actions taking place regarding hospital acquired thrombosis, following a review of patients from 2015/16. The Committee were also informed that the results of the GMC trainee survey 2016 had been released in July. Overall East and North Hertfordshire NHS Trust had shown year on year improvement reflected in reduced negative outliers for 2016. The Committee would receive a full review of the survey's findings at a future meeting. It was also noted that the new junior doctor trainee contract was being implemented from October 2016. The Committee noted the report.

Workforce Paper – NHS Workforce Race Equality Standard

The Committee reviewed the Workforce Race Equality Standard submission for 2016. The Trust's position had improved on the previous year's submission in most areas. The Committee supported the submission.

<u>The following reports were noted by the Committee:</u>

1. **Safeguarding Children Annual Report**
   The Committee noted the Safeguarding Children Annual Report 2015-16, which provided an overview of safeguarding children services, standards and outcomes from April 2015 to March 2016. Safeguarding Level 3 training compliance was below the 95% target now set by the CCG and work was underway to improve this. It was also noted that there had been an increase in activity with regard to Safeguarding Children.

2. **Pathology Performance Update and Recovery Plan**
   The Committee noted the Pathology Performance Update and Recovery Plan, acknowledging that the latest situation remained similar to that detailed in the update received in July. It was noted that service levels continued to improve. The Committee requested a further update on cancer related performance in the next report.

3. **Compliance Update**
   The Committee received an update regarding compliance with Care Quality Commission (CQC) requirement notices and feedback from the CQC Quality Development Board and recent CQC Engagement Meeting. The Committee noted the report.

4. **Safer Nurse Staffing Levels**
   The Committee noted the Safer Nurse Staffing Levels reports for July and August. It was noted that overall Registered Nurse fill rate had decreased in August due to short term sickness, annual leave being towards the upper end of the threshold and an increase in unfilled temporary staffing shifts.

5. **Infection Prevention and Control**
   The Committee received the Infection Prevention and Control report. There had been 9 hospital acquired C.difficile cases in in the year to date, 4 of which the Trust was appealing. The Committee also noted the ongoing IT interface issue which was yet to be resolved and was currently requiring a manual workaround.

Data Pack
The Committee noted the following report included within the Data Pack:
1. PALS and Complaints Monthly Report

The following points are specifically highlighted to the Trust Board:

1. Discussion – Strategic Risk
The Committee had an open discussion regarding strategic risk. This was following the findings of the Committee's annual review which had concluded that strategic risk was an area of the Committee's remit where further work could be done. It was agreed that a discussion on strategic risk would be a standing item on RAQC agendas from November 2016. This would include consideration of an item on the Board Assurance Framework relevant to the remit of the Committee and enable a focus on the actions being taken and any emerging new risks. The first area to be reviewed was agreed as capacity and demand. Also this item in future would take the opportunity to horizon scan any emerging external risks.

2. Estates Risks and Incidents - MVCC
The Committee received a report which provided an update on estates related risks at Mount Vernon Cancer Centre. It was noted that due to the age of the site, significant investment would be needed to address the backlog of maintenance required. Further assurance on ensuring the current business continuity plans were updated and understood was requested. Further discussion would take place at Trust Board Part II.

3. Mortality Report
The Medical Director presented the Mortality Report. The HSMR was 94.70 for the period June 2015 to July 2016 and was statistically 'lower than expected'. The SHMI for the period April 2015 to March 2016, due to be officially released the day after the meeting, was 106.2 and was the Trust's best ever rate for this indicator. Highlights from the report included continued improvements within stroke care to improve outcomes for patients, progress with regard to the mortality review process and the Acute Chest Team service being shortlisted for the 'respiratory service category' in the Nursing Times Awards. The Committee was assured by the report.

John Gilham
Chairman

September 2016

Agenda Item: 12

TRUST BOARD MEETING (PART I) – 28 SEPTEMBER 2016

AUDIT COMMITTEE REPORT TO BOARD

PURPOSE	To present to the Trust Board the report from the Audit Committee (AC) meeting of 1 August 2016
PREVIOUSLY CONSIDERED BY	N/A
Objective(s) to which issue relates *	✓ **1. Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ✓ **2. Developing new services and ways of working** – delivered through working with our partner organisations ✓ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key assurance committee reporting to the Board
Healthcare/ National Policy (includes CQC/Monitor)	In line with Standing Orders and best practice in corporate governance
CRR/Board Assurance Framework *	✓ **Corporate Risk Register** ✓ **BAF**

ACTION REQUIRED *

For approval	✓	For decision	
For discussion		For information	

DIRECTOR:	CHAIR OF AUDIT COMMITTEE
PRESENTED BY:	CHAIR OF AUDIT COMMITTEE
AUTHOR:	BOARD COMMITTEE SECRETARY/COMPANY SECRETARY
DATE:	AUGUST 2016

We put our patients first We work as a team We value everybody We are open and honest
We strive for excellence and continuous improvement

* tick applicable box

AUDIT COMMITTEE – MEETING HELD ON 1 AUGUST 2016

SUMMARY REPORT TO BOARD – 28 SEPTEMBER 2016

The following members were present: Alison Bexfield, Julian Nicholls, Bob Niven
Other directors in attendance: Brian Steven

OUTCOMES

Internal Audit Progress Report

The AC received the latest IA progress report including findings of audits completed since the previous AC on Non-pay Expenditure (amber red, partial assurance) and Divisional Governance, Medicine and Surgery (amber red, partial assurance). The report also included an advisory report following a review of effective rostering. Discussion focussed on the following:

- The AC endorsed all finance managers would be issued with a declaration of understanding of Standing Financial Instructions for sign-off that authorisation limits were understood including consequences of non-adherence. The Committee supported regular budget holder training, a re-audit during August of progress on the implementation of recommendations made and report back to AC in October.

- The AC discussed findings of the divisional governance audit within Medicine and Surgery and agreed it was crucial to spread good practice identified in some parts of the organisation across all areas.

- The AC anticipated good progress on management action recommendations of both audits by the end of the year.

Local Counter Fraud Specialist Progress Report

The AC received an update on counter fraud work undertaken since May 2016; four cases had been brought forward from 2015/16 and two investigations had been opened to date 2016/17. The AC reviewed details of referrals. The AC was assured a proactive audit on Conflicts of Interest forms part of the Counter Fraud audit plan for the current year. The AC welcomed the Trust's NHS Protect Self Review Tool green rating assessment that the Trust was compliant with standards.

Internal Audit Tracking Report

The AC reviewed the latest IA tracking report of recommendations made noting a total of nine were overdue whilst the target date for the remaining three had not been reached. The AC agreed the two actions overdue more than six months would be removed since these had a high level of scrutiny at Executive and Trust Board level.

External Audit Annual Audit Letter 2015/16/EA report on Quality Account

The AC examined the EA Annual Audit Letter (see appendix A) summarising key issues arising from work carried out in respect of the year ended 2015/16 which would also be for public consumption. The Audit conclusions on the Trust's financial statements, use of resources and Quality Account had previously been reviewed by the AC in May and June 2016. In summary EA issued:

- an unqualified, true and fair opinion on the financial statements;
- a qualified conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources;
- an unqualified assurance report on the Quality Account.

The AC noted the EA report on the Trust's Quality Account.

Other matters:

Business Continuity IT service/Disaster Recovery
The AC had a lengthy debate on business/IT service continuity/disaster recovery and was concerned the report presented did not provide adequate assurance of the Trust's business continuity plans. The AC recommended exploration of an external body to undertake a review of current processes. The AC approved further discussion would take place at Executive Committee prior to consideration at Trust Board, Part II.

Significant Losses/Special Payments
The AC received the Losses and Special Payments twice-yearly report covering activity from October 2015-March 2016 including comparison data for the previous four six-monthly periods. The AC noted a summary of complaint settlements included a number of settlements made to reimburse parking and travel costs. The AC received assurance the increase in unpaid prescription charges mainly related to an out-of-hours control issue. The AC supported future summaries of debts written off would include stock write-offs.

Raising Concerns at Work
The AC received its twice-yearly update on progress with raising concerns cases including a summary of actions currently being undertaken and proposals for new actions going forward following the introduction of the Freedom to Speak Up Guardian from October 2016 (the Company Secretary would undertake this role following recommendation by the RAQC in April 2016). The AC noted five new cases had been raised to date 2016/17 of which three were currently open. The AC was assured further promotion of the Raising Concerns Policy (positively received by staff) would be undertaken; referrals were not deemed malicious.

Standing Financial Instructions and Standing Financial Orders
The AC considered the annual review of the Standing Financial Instructions and Standing Financial Orders undertaken by the Company Secretary, LCFS, finance and procurement teams (see Appendix B); this had been brought forward taking into account the Board moving to meeting alternate months to ensure committees had the approved delegated authorities. The AC made recommendations to simplify the language used, provide staff training and include a front sheet explaining the consequences of non-adherence. A further version would be circulated by email for AC approval and recommendation of final approval at Trust Board in September.

Committee Evaluation 2015-16
The AC agreed to defer the Audit Committee Evaluation 2015/16 to October's AC meeting to enable input by internal and external auditors.

Alison Bexfield
Non-Executive Director

August 2016

TRUST BOARD COMMITTEE (PART I) – 28 SEPTEMBER 2016

EXTERNAL AUDIT ANNUAL AUDIT LETTER 2015/16

PURPOSE	To present to Trust Board the External Auditor's Annual Audit Letter for the year ended 31 March 2016
PREVIOUSLY CONSIDERED BY	Audit Committee
Objective(s) to which issue relates *	✓ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ✓ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ✓ 3. **Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key to providing the Board with assurance on the management of the Trust's corporate objectives and statement on internal control.
Healthcare/ National Policy (includes CQC/Monitor)	Any potential risks are identified in the individual reports
CRR/Board Assurance Framework *	✓ **Corporate Risk Register** ✓ **BAF**

ACTION REQUIRED *

For approval	✓	For decision	
For discussion		For information	

DIRECTOR:	Director of Finance
PRESENTED BY:	External Auditors
AUTHOR:	External Auditors
DATE:	September 2016

We put our patients first We work as a team We value everybody We are open and honest
We strive for excellence and continuous improvement

* tick applicable box

PUBLIC SECTOR ASSURANCE

EAST AND NORTH HERTFORDSHIRE NHS TRUST

ANNUAL AUDIT LETTER | Audit for the year ended 31 March 2016
21 July 2016

DAVID EAGLES
Engagement Lead

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EXECUTIVE SUMMARY

Purpose of the letter

This Annual Audit Letter summarises the key issues arising from the work that we have carried out in respect of the year ended 2015/16. It is addressed to the Trust but is also intended to communicate the key findings we have identified to key external stakeholders and members of the public. It will be published on the website of Public Sector Audit Appointments Limited.

Responsibilities of auditors and the Trust

It is the responsibility of the Trust to ensure that proper arrangements are in place for the conduct of its business and that public money is safeguarded and properly accounted for.

Our responsibility is to plan and carry out an audit that meets the requirements of the NAO's Code of Audit Practice (the Code), and to review and report on:

- the Trust's financial statements
- whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are also required to review and report on the governance statement, annual report, remuneration report and the accounts summarisation schedules.

We also undertake a review of the Trust's Quality Account, to confirm that it has been prepared in line with requirements and to test two performance indicators.

We recognise the value of your co-operation and support and would like to take this opportunity to express our appreciation for the assistance and co-operation provided during the audit.

BDO LLP

21 July 2016

Audit conclusions

FINANCIAL STATEMENTS

We issued an unqualified true and fair opinion on the financial statements on 2 June 2016.

We reported our detailed findings to the Audit Committee on 23 May 2016.

USE OF RESOURCES

We reported by exception in relation to the arrangements in place to secure economy, efficiency and effectiveness as we concluded that there were material uncertainties regarding the financial position, projections and financial management capacity.

QUALITY ACCOUNT

We issued an unqualified assurance report on the Quality Account on 22 June 2016.

We reported our detailed findings in a separate report on 21 June 2016.

FINANCIAL STATEMENTS

OPINION	We issued an unqualified true and fair opinion on the financial statements on 2 June 2016.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that they are free from material misstatement, whether caused by fraud or error.

This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates, and the overall presentation of the financial statements.

Our assessment of risks of material misstatement

Our audit was scoped by obtaining an understanding of the Trust and its environment, including the system of internal control, and assessing the risks of material misstatement in the financial statements.

We set out below the risks that had the greatest effect on our audit strategy, the allocation of resources in the audit, and directing of the efforts of the audit team.

MANAGEMENT OVERRIDE OF CONTROLS	RESPONSE	FINDINGS
Auditing standards presume that a risk of management override of controls is present in all entities and require us to respond to this risk by testing the appropriateness of accounting journals and other adjustments to the financial statements, reviewing accounting estimates for possible bias and obtaining an understanding of the business rationale of significant transactions that appear to be unusual. By its nature, there are no controls in place to mitigate the risk of management override	We reviewed accounting estimates for bias and evidence of manipulation by management, challenging the key assumptions that were made. We carried out detailed testing on journal entries by targeting transactions that we identified to have a higher risk of management override and ensured from this selection that the journal entries had been appropriately posted. We had discussions with a number of different individuals within the organisation to identify if they were aware of any fraudulent activity.	No evidence of management override was noted from testing.

FINANCIAL STATEMENTS
Continued

REVENUE RECOGNITION	RESPONSE	FINDINGS
Auditing standards presume there is a risk of fraud in relation to revenue recognition. The majority of the Trust's income is from NHS commissioners for the provision of healthcare. No reason was identified to rebut the presumed risk of fraud in relation to revenue recognition.	For NHS revenue, we reviewed the results of the agreement of balances exercise with other NHS bodies and investigated discrepancies highlighted by the mismatch reports. For Non NHS revenue, we took a sampling approach to testing the balance, vouching the sampled items back to relevant supporting information. Both NHS and Non NHS revenue were also reviewed in total analytically and variances above a set threshold were investigated to ensure that the overall revenue balance was accurate. We also reviewed the revenue accounting policy for consistency with the Manual for Accounts and performed cut off testing around the year end to ensure that revenue was recorded in the correct period. We took assurance from the work that was completed within the Property Plant and Equipment section over the gain on disposal of assets, where we confirmed the correct amount had been recognised by reference to disposal proceeds and the cost of the asset being disposed. Finally, we took assurance from the work completed over the trade and other receivables balances, which reviewed a number of year end balances and confirmed these to pre year end supporting documentation and post year end payment receipts into the bank.	No non trivial errors were noted from testing of revenue.

FINANCIAL STATEMENTS

Continued

QEII- DISPOSAL OF LAND	RESPONSE	FINDINGS
There has been a disposal of QEII land within the year which was completed on 31/03/2016. Of this disposal, all cash was received prior to the year end with the exception of £1m retention. The Trust proposed to recognise £750k of this as part of the proceeds in the current year, as the expected future costs of disposal are £250k. There is a risk that the proceeds of this disposal are recognised too early, or are inflated.	Testing was carried out to ensure that the surplus on the disposal of the land was recognised correctly in the financial statements by checking the proceeds back to the completion statement/bank statements and checking the cost to the fixed asset register. The retention receivable of £1m was specifically reviewed to ensure that this had been recognised in the correct period.	Work performed concluded that the correct profit on disposal had been recognised and the retention specifically had been posted for an appropriate amount within the calculations.

QEII -DEVELOPMENT COSTS	RESPONSE	FINDINGS
The Trust has an operating lease arrangement in respect of the new QEII site. The Trust incurred development costs prior to moving in to the building of £1.2m and recognised these as prepayments to be spread over the course of the lease. There is a risk that these costs should have been treated as revenue expenditure within the year under IAS17	We reviewed the technical paper provided by the Trust over the treatment of development costs in respect of the lease on the new QEII building and ensured that this was consistent with the requirements of the manual for accounts/IFRS where relevant, with reference to the terms disclosed in the lease agreement of QEII.	The Trusts approach was found to be consistent with the MfA and IAS17 taking into consideration the fact that the payments were made as "lease payments" under the lease agreement. Therefore no adjustments were proposed.

THE PATHOLOGY PARTNERSHIP (tPP) RECOGNITION	RESPONSE	FINDINGS
In 2014/15, the pathology partnership which ENHT owned a 19.14% share of was not included as an associate. Following tPP's significant deficits over the past 2 years, a review of the investment for impairment will be required which relies on detailed forecasts and as a result as with all forecasts the calculations include a number of unknown variables. There is a risk that the investment has not been treated correctly in the financial statements, and that the investment may require a complex impairment calculation to be performed.	Testing was carried out over the classification of the investment by review of IFRS11 and IFRS12, with reference to the level of influence that ENHT had over tPP. In addition, testing was carried out to challenge the assumptions of the tPP business forecasts that had been incorporated by the Trust in preparing a valuation to determine whether an impairment to the investment was required. Discussions were held with the Chief Operating Officer of tPP as well as through scrutiny of the forecasts, taking reference to the report produced by PwC on the turnaround plan and further supporting data provided.	tPP was found to have been appropriately classified within the financial statements. An impairment to the investment of £2,372k was suggested as a result of the review. This was adjusted by ENHT in the final financial statements.

FINANCIAL STATEMENTS
Continued

Our application of materiality

We apply the concept of materiality both in planning and performing our audit, and in evaluating the effect of misstatements.

We consider materiality to be the magnitude by which misstatements, including omissions, could influence the economic decisions of reasonably knowledgeable users that are taken on the basis of the financial statements.

Importantly, misstatements below these levels will not necessarily be evaluated as immaterial as we also take account of the nature of identified misstatements, and the particular circumstances of their occurrence, when evaluating their effect on the financial statements as a whole.

The materiality for the financial statements as a whole was set at £6.7 million. This was determined with reference to a benchmark of gross expenditure (of which it represents 2 per cent) which we consider to be one of the principal considerations for the Trust in assessing the financial performance.

We agreed with the Audit Committee that we would report all individual audit differences in excess of £135,000.

Audit differences

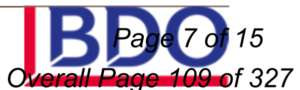
There were no unadjusted audit differences.

Summarisation schedules return

We are required to provide an opinion to the Trust to confirm that the financial information included in its accounts summarisation schedules return (and used in the preparation of the Group consolidation) is consistent with the audited financial statements.

We reported that the summarisation schedules were consistent with the financial statements except for the following:

- The FMAs were consistent with the single entity figures disclosed in the Trust's financial statements but not consistent with the consolidated group information as the FMAs were prepared under a single entity basis.



FINANCIAL STATEMENTS
Continued

Governance statement

The governance statement was not inconsistent or misleading with other information we were aware of from our audit of the financial statements, the evidence provided in the Trust's review of effectiveness and our knowledge of the Trust.

Annual Report

The Annual Report was not inconsistent or misleading with the financial statements or with our knowledge acquired in the course of our audit.

Remuneration Report

The auditable parts of the Remuneration Report was found to have been properly prepared in accordance with the requirements directed by the Secretary of State.

Internal controls

We did not find any significant deficiencies in internal controls during the course of our audit. A number of other areas for improvement were identified which we have discussed with management.

USE OF RESOURCES

CONCLUSION	We issued a qualified conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources on 2 June 2016.

Scope of the audit of use of resources

We are required to be satisfied that proper arrangements have been made to secure economy, efficiency and effectiveness in the use of resources based on the following reporting criterion:

- In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

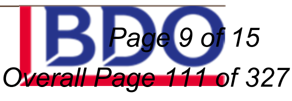
As part of reaching our overall conclusion we consider the following sub criteria in our work: informed decision making, sustainable resource deployment, and working with partners and other third parties.

Our assessment of significant risks

Our audit was scoped by our cumulative knowledge brought forward from previous audits, relevant findings from work undertaken in support of the opinion on financial statements, reports from the Trust including internal audit, information disclosed or available to support the governance statement and annual report, and information available from the risk registers and supporting arrangements.

We set out below the risks that had the greatest effect on our audit strategy, the allocation of resources in the audit, and directing of the efforts of the audit team.

FINANCIAL SUSTAINABILITY	RESPONSE	FINDINGS
At the time of drafting the Audit Plan, the Trust was projecting to achieve a deficit of £8m, but subject to additional pressures from tPP and other technical accounting issues. The cash position was challenging, and support was being sought. The Long Term Financial Model (LTFM) was showing a slight deterioration. The wider health economy includes a number of notably distressed organisations. During the period, the projected outturn was revised downwards to a projected £12m deficit, but with various risk issues (including asset sale) giving a range of up to £20m deficit.	We: • reviewed the Trust's in year budget monitoring and its annual budgets submitted to the Trust Development Authority (TDA), including the reasonableness of the underlying assumptions made by management and the consideration of risks to sustainable deployment of resources. • reviewed progress against the CIP planned savings and arrangements to ensure that future targets are realistic and achievable, including working with commissioners and other third parties to develop required savings schemes. • compared the key financial and activity assumptions used in the 2016/17 Operational Financial Plan against suggested data provided by the Department of Health and NHS England.	For 2015/16 the Trust planned for a deficit of £8million. However, the actual out-turn was a deficit of £16.0 million, the main variances being the increase in agency spend, failure to secure £4m of commissioner income which had been negotiated during the year and additional investment required in A&E following the CQC report. Overall, there appears to have been a robust process in place for reviewing the on-going performance and appropriate challenge has been made at Board and Committee level. The plan for 2016/17 forecasts a deficit of £23.8m, assuming the delivery of £15.5 million of CIPs. The Trust has a good record for delivery of CIPs over the last 4 years with all CIP schemes being clinically-led and progress on delivery being reported to the Finance and Performance Committee on a monthly basis. All schemes are signed off from a quality perspective by the Medical Director and Director of Nursing. There is a concern from certain Board members that the schemes are only developed on an annual basis rather than being viewed in a more strategic long term way and being developed on a rolling basis.



USE OF RESOURCES
Continued

FINANCIAL SUSTAINABILITY	RESPONSE	FINDINGS
As described above.	As described above.	Senior management does not anticipate that the Trust will be able to recover from its deficit position in the near term unless they receive significant additional funding. Although the Trust is actively working with partner organisations on the Sustainability and Transformation Plan, and has put in place a Financial Recovery Board to progress and manage this, there is currently no agreed recovery plan in place for the Trust. There are concerns that the Bedfordshire STP is being developed separately to the Hertfordshire Plan, however the Trust has a significant number of patients from Bedford. The Trust has established working relationships with the Local Authority and there is a Care Home Vanguard in place. The Trust has evidenced successful negotiations with East and North Hertfordshire CCG relating to positive collaborations in addressing a number of complex areas Overall, financial management arrangements in place appear reasonable. However, there are certain areas where further improvements are considered possible by management/Board members: • Service Level Reporting (SLR) – The Trust is in the process of implementing SLR reporting which will provide operational managers and clinical leads with more robust financial data. • Reporting and strategic support – there are potential capacity issues and on occasion reports have been issued late to Board members. Also the format of the finance report has been recently reviewed and a new style report is now being used. • There is a view from certain Board members that further strategic financial support could be provided to the Clinical Divisions to help support them on the wider business agenda. *Strategic procurement* The Trust is a member of the Hertfordshire Procurement Hub and is involved in the national work on procurement from a clinical perspective. In light of the opportunities identified in the Lord Carter Report on procurement ,at the Trust it would appear that there are further opportunities. Work is on-going at the Trust, with executive lead looking at procurement processes and collaborative working with other organisations to ensure these opportunities are fully realised.

USE OF RESOURCES

Continued

FINANCIAL SUSTAINABILITY	RESPONSE	FINDINGS
As described above.	As described above.	*Performance Management* The Trust executives hold weekly meetings with the Divisional Management Teams to monitor performance and to hold the Divisions to account. Each weekly meeting covers a different aspect of business, with one meeting being focused on financial performance and CIP delivery. The Trust has been looking at the workings of the Board and senior management and has employed external consultants to deliver Board Development and Senior Management Development. *IM&T* The Trust's Patient Administration System is no longer supported by the provider, so needs to be replaced. A Business Case is due to be approved by the Board in May to replace the system, however the timescales are very tight for implementation, as part of the system needs to be operational by July 2016. The overall project will run to July 2017. The Board has been discussing this for many months and mitigation is in place to ensure the current system remains operational until the new one is implemented.

QUALITY ACCOUNT

CONCLUSION	We issued an unqualified assurance report on the Quality Account on 22 June 2016.

Scope of the review of the Quality Account

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

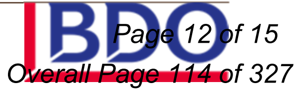
- the Quality Account is not prepared in line with the criteria set out in the Regulations
- the Quality Account is not consistent with the sources specified in the NHS Quality Accounts Auditor Guidance
- the two performance indicators subject of limited assurance review are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Specified indicators for testing

The core set of indicators to be included in 2015/16 Quality Account is set out in Regulations and the letter from NHS England dated 3 February 2016. The Auditor Guidance has not been updated since 2014/15, and requires that we selected two indicators for testing from the following list:

- Percentage of patients risk-assessed for venous thromboembolism (VTE)
- Rate of clostridium difficile infections
- Percentage of patient safety incidents resulting in severe harm or death
- Friends and Family Test patient element score.

REQUIREMENTS	RESPONSE	FINDINGS
Review the content of the report and consistency with specified documents.	We reviewed the contents of the Quality Account and compared this to the guidance and Regulations issued by the Department of Health. We read the information included in the Quality Account and considered whether it was materially inconsistent with: • Board minutes and papers relating to quality reported to the Board • feedback from Commissioners, Local Healthwatch and Overview and Scrutiny Committee • the Trust's complaints report • latest national patient survey and staff survey • Head of Internal Audit's annual opinion over the Trust's control environment • the annual governance statement • Care Quality Commission's quality and risk profiles • results of the latest Payment by Results coding review.	The Quality Account has been prepared in line with the Regulations. We reported to management where there are omissions or where additional information and disclosure is required to comply with the guidance issued by NHS England. These amendments have been made to the final published version. The Quality Account is not materially inconsistent with our review of the information we are required to consider.



QUALITY ACCOUNT
Continued

REQUIREMENTS	RESPONSE	FINDINGS
Percentage of patients risk-assessed for venous thromboembolism (VTE). The Trust reported 96.7% of relevant patients in the period October to December 2015 had been risk assessed for VTE, 96.3% in July to September 2015 and 95% in April to June 2015.	We undertook testing to: • confirm the definition and guidance used by the Trust to calculate the indicator • document and walk through the Trust's systems used to produce the indicator • undertake substantive testing on the underlying data against six specified data quality dimensions. We tested of a sample of 45 cases included in the reported performance.	We found no significant weaknesses in the systems use to produce the indicator. For each case tested, the information was agreed to underlying records and had applied the appropriate guidance.
Percentage of patient safety incidents resulting in severe harm or death. The Trust reported 17 (0.6%) incidents of severe harm or death to the National Reporting and Learning System (NRLS) for the reporting period April to September 2015. The Trust also reported comparative periods October 14 – March 15 (15 incidents of severe harm or death - 0.6%) and April 14 to Sept 14 (15 incidents of severe harm or death – 0.6%).	We undertook testing to: • confirm the definition and guidance used by the Trust to calculate the indicator • document and walk through the Trust's systems used to produce the indicator • undertake substantive testing on the underlying data against six specified data quality dimensions. We tested of a sample of 45 cases included in the reported performance.	Our testing of a sample of cases, including cases recorded below severe harm, did not indicate any concerns with the accuracy of the underlying data. However, issues were noted in respect of the timeliness and completeness of reports being provided to the NRLS, as well as a transposition error in the information transferred from the NRLS to the quality accounts. Whilst technically the Trust was complying with the indicator definition in that NRLS statistics had been used, the data submitted upon which this was based was not complete and so the indicator information reported needed to be corrected.

APPENDIX

Reports issues

We issued the following reports in respect of the 2015/16 financial year.

REPORT	DATE
Planning letter	April 2015
Audit Plan	January 2016
Final audit report	May 2016
Quality Account	June 2016
Annual Audit Letter	July 2016

Fees

We reported our original fee proposals in our Audit Plan. We have not had to amend our planned fees.

AUDIT AREA	PLANNED FEES	FINAL FEES
Code audit	79,088	79,088
Non audit service fees		
- Quality Account review	10,000	10,088
Total	89,088	89,088

The matters raised in our report prepared in connection with the audit are those we believe should be brought to the attention of the organisation. They do not purport to be a complete record of all matters arising.. No responsibility to any third party is accepted.

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Agenda Item: 12.2

TRUST BOARD COMMITTEE (PART I) – 28 SEPTEMBER 2016

STANDING FINANCIAL INSTRUCTIONS AND STANDING FINANCIAL ORDERS

PURPOSE	To present Trust Board the annual review of the Standing Financial Instructions and Standing Financial Orders for consideration and approval. *(Tracked changes have been used for ease).* N.B. Since the Audit Committee the Finance Team have established a number of other mechanisms to continue to improve the control environment and ensure staff are aware of their responsibilities These were reported to FPC in September 2016. A newsletter on SFI's/SFOs has been developed and will be communicated in the next 2 weeks. This is aimed towards the budget holders to ensure their understanding of the key sections relevant to them and potential consequences if they are not followed.
PREVIOUSLY CONSIDERED BY	Audit Committee, Review by Company Secretary, Financial Controller, Deputy Director of Finance, Procurement & LCFS.
Objective(s) to which issue relates *	✓ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ✓ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key element of the Trust's governance processes.
Healthcare/ National Policy (includes CQC/Monitor)	Supports compliance with Corporate Governance requirements. In line with best practice
CRR/Board Assurance Framework *	✓ **Corporate Risk Register** ✓ **BAF**

ACTION REQUIRED *

For approval	✓	For decision	☐
For discussion	☐	For information	☐

DIRECTOR:	Chief Executive
PRESENTED BY:	Company Secretary
AUTHOR:	Company Secretary
DATE:	September 2016

We put our patients first We work as a team We value everybody We are open and honest
We strive for excellence and continuous improvement

REVIEW OF STANDING FINANCIAL INSTRUCTIONS
AND STANDING FINANCIAL ORDERS – 2016

1. EXECUTIVE SUMMARY

The annual review of standing financial instructions and standing financial orders has been undertaken by the Company Secretary, LCFS, finance and procurement teams. In particular the scheduled review this year took into account the Board moving to meeting alternate months and ensures committees have the approved delegated authorities, including the newly established Auditor Panel and any requirements to strengthen procurement.

The key changes are outlined below:

- Updated to reflected the current Board Committees that are established to discharge the trust responsibilities, including the new Auditor Panel. The Auditor Panel has been established 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 and ensure the 2017/18 appointment is made by 31st December 2016. (Appendix 1)
- Minor updates to reflect the Organisational changes in the NHS. (Appendix 1)
- Although no changes to the levels of financial scheme of delegation have are proposed this year, the OJEU limit is corrected and "HSMC" replaced by "Procurement." (Appendix 2)

Tracked changes have been used in the document to identify the key changes, these will be removed and the contents pages finalised once the content of the document has been approved.

To further support compliance with the SFI's, SFO's and financial control:

- Each budget manager has been sent a letter from the Chief Executive with the updated SFI's and SFO's reminding them of their roles and responsibilities and requesting the return of a declaration form to note they have read and understood this. These are being collated by the Finance Department.
- Procurement has developed a flowchart on the process to follow for Good and Services, see appendix 3.
- Since the Audit Committee the Finance Team have established a number of other mechanisms to continue to improve the control environment and ensure staff are aware of their responsibilities These were reported to FPC in September 2016.
- A newsletter on SFI's/SFOs has been developed and will be communicated in the next 2 weeks. This is aimed towards the budget holders to ensure their understanding of the key sections relevant to them and potential consequences if they are not followed.

The Board is asked to note the additional measures being taken and to approve the revised SFI's and SFO's, appendix 1 and 2.

TRUST-WIDE POLICY

for

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

A document recommended for use

In: Trust-wide

By: All staff

For: NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted.
High standards of corporate and personal conduct are essential in the NHS. These "extended" Standing Orders, incorporating the Standing Financial Instructions (SFIs), Schedule of Reservations of Powers (SRP) and Scheme of Delegated Authorities (SoDA) identify who in the Trust is authorised to do what.

Key Words: Policy, Standard Financial Instructions, Standing Financial Orders, Finance, Governance, Delegated Authorities

Written by: Company Secretary
Financial Controller
Head of Procurement
Local Counter Fraud Specialist

Approved by: Audit Committee ……………………………………………….
Mrs Alison Bexfield (Chairman), August 2016

Trust Ratification: Trust Board ……………………………………………………..
Mrs Ellen Schroder ~~Ian Morfett~~ (Trust Chair), xx September 2016

Policy issued: October 2015

To be reviewed before: October 2016

To be reviewed by: Company Secretary

Doc Registration No. CG05 **Version No.** 6~~5~~

EAST AND NORTH HERTFORDSHIRE NHS TRUST

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

October 201~~6~~5

Final approval by Board October 2015 – reviewed

CONTENTS **Page**

SECTION A

INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS **9**

SECTION B – STANDING ORDERS **11**

1.	**INTRODUCTION**	11
1.1	Statutory Framework	11
1.2	NHS Framework	11
1.3	Delegation of Powers	11
2.	**THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS**	**12**
2.1	Composition of the Trust Board	**12**
2.2	Appointment of the Chairman and Members	**12**
2.3	Terms of Office of the Chairman and Members	**13**
2.4	Appointment and Powers of Vice-Chairman	**13**
2.5	Joint Members	**13**
2.6	Patient and Public Involvement Forum	**13**
2.7	Role of Members	**14**
2.8	Corporate Role of the Board	**14**
2.9	Schedule of Matters Reserved to the Board and Scheme of Delegation	**15**
2.10	Lead Roles for Board Members	**15**
3.	**MEETINGS OF THE TRUST**	**15**
3.1	Calling Meetings	**15**
3.2	Notice of Meetings and the business to be transacted	**15**
3.3	Agenda and Supporting Papers	**16**
3.4	Petitions	**16**
3.5	Notice of Motion	**16**
3.6	Emergency Motions	**16**
3.7	Motions: Procedure at and during a meeting	**16**
	(i) who may propose	**16**
	(ii) contents of motions	**16**
	(iii) amendments to motions	**17**
	(iv) rights of reply to motions	**17**
	(v) withdrawing a motion	**17**
	(vi) motions once under debate	**17**
3.8	Motion to Rescind a Resolution	**17**
3.9	Chairman of meeting	**18**
3.10	Chairman's ruling	**18**
3.11	Quorum	**18**
3.12	Voting	**18**
3.13	Suspension of Standing Orders	**19**
3.14	Variation and amendment of Standing Orders	**19**
3.15	Record of Attendance	**19**
3.16	Minutes	**20**
3.17	Admission of public and the press	**20**
3.18	Observers at Trust meetings	**21**
4.	**APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES**	**21**

CONTENTS **Page**

4.1	Appointment of Committees	**21**
4.2	Joint Committees	**21**
4.3	Applicability of Standing Orders and Standing Financial Instructions to Committees	**21**
4.4	Terms of Reference	**21**
4.5	Delegation of powers by Committees to Sub-Committees	**21**
4.6	Approval of Appointments to Committees	**22**
4.7	Appointments for Statutory functions	**22**
4.8	Committees to be established by the Trust Board	**22**
4.8.1	Audit Committee	**22**
4.8.2	Remuneration and Terms of Service Committee	**22**
4.8.3	Trust and Charitable Funds Committee	**23**
4.8.4	Other Committees	**23**
5.	**ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION**	23
5.1	Delegation of functions to Committees, Officers or other bodies	**23**
5.2	Emergency powers and urgent decisions	**24**
5.3	Delegation of Committees	**24**
5.4	Delegation of Officers	**24**
5.5	Schedule of matters reserved to the Trust and Scheme of Delegation of Powers	**24**
5.6	Duty to report non-compliance with Standing Orders and Standing Financial Instructions	**24**
6.	**OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS**	24
6.1	Policy statements: general principles	**24**
6.2	Specific Policy statements	**25**
6.3	Standing Financial Instructions	**25**
6.4	Specific guidance	**25**
7.	**DUTIES AND OBLIGATIONS OF BOARD MEMBERS, MEMBERS, DIRECTORS AND SENIOR MANAGERS UNDER THE STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS**	25
7.1	Declaration of Interests	**25**
7.1.1	Requirements for Declaring Interests and applicability to Board members	**25**
7.1.2	Interests which are relevant and material	**25**
7.1.3	Advice on Interests	**26**
7.1.4	Recording of Interests in Trust Board minutes	**26**
7.1.5	Publication of declared interests in Annual Report	**26**
7.1.6	Conflicts of interest which arise during the course of a meeting	**26**
7.2	Register of Interests	**26**
7.3	Exclusion of Chairman and Members in Proceedings on Account of Pecuniary Interest	**27**
7.3.1	Definition of terms used in interpreting 'Pecuniary' interest	**27**
7.3.2	Exclusion in proceedings of the Trust Board	**28**
7.3.3	Waiver of Standing Orders made by the Secretary of State for Health	**28**
7.4	Standards of Business Conduct Policy	**30**
7.4.1	- Trust Policy and National Guidance	**30**
7.4.2	- Interest of Officers in Contracts	**30**
7.4.3	- Canvassing of, and Recommendations by, Members in relation to appointments	**30**
7.4.4	- Relatives of Members or Officers	**30**
8.	**CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF**	

CONTENTS **Page**

DOCUMENTS **31**

8.1 Custody of Seal **31**
8.2 Sealing of Documents **31**
8.3 Register of Sealing **31**
8.4 Signature of documents **31**

9. MISCELLANEOUS **31**

9.1 Joint Finance Arrangements **31**
SECTION C – RESERVATION and DELEGATION of POWERS **32**

SECTION D – STANDING FINANCIAL INSTRUCTIONS **58**

10. INTRODUCTION **58**

10.1 General **58**
10.2 Responsibilities and delegation **58**
10.2.1 The Trust Board **58**
10.2.2 Ditto **58**
10.2.3 The Chief Executive and Director of Finance **59**
10.2.4 ditto **59**
10.2.5 The Director of Finance **59**
10.2.6 Board Members and Employees **59**
10.2.7 Contractors and their employees **60**
10.2.8 Ditto **60**

11. AUDIT **60**

11.1 Audit Committee **60**
11.1.1 ditto **60**
11.1.2 ditto **60**
11.1.3 ditto **60**
11.2 Director of Finance **61**
11.2.1 ditto **61**
11.2.2 ditto **61**
11.3 Role of Internal Audit **61**
11.3.1 ditto **61**
11.3.2 ditto **62**
11.3.3 ditto **62**
11.3.4 ditto **62**
11.4 External Audit **62**
11.4.1 ditto **62**
11.5 Fraud and Corruption **62**
11.5.1 ditto **62**
11.5.2 ditto **62**
11.5.3 ditto **62**
11.5.4 ditto **62**
11.6 Security Management **62**
11.6.1 ditto **62**
11.6.2 ditto **62**
11.6.3 ditto **63**

12.	**RESOURCE LIMIT CONTROL**	**63**
13.	**ALLOCATIONS, PLANNING, BUDGETS, AND MONITORING BUDGETARY CONTROL**	**63**
14.	**ANNUAL ACCOUNTS AND REPORTS**	**65**
15.	**BANK AND GBS ACCOUNTS**	**65**
16.	**INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS**	**66**
17.	**TENDERING AND CONTRACTING PROCEDURE**	**67**
17.1	General	**67**
17.2	Duty to comply with Standing Orders and Standing Financial Instructions	**68**
17.3	EU Directives Governing Public Procurement	**68**
17.4	Reverse eAuctions	**68**
17.5	Capital Investment Manual and other Department of Health guidance	**68**
17.6	Formal Competitive Tendering	**68**
17.6.1	General Applicability	**68**
17.6.2	Health Care Services	**68**
17.6.3	Exceptions and instances where formal tendering need not be applied	**69**
17.6.4	Building and Engineering Construction Works	**70**
17.6.5	Items which subsequently breach thresholds after original approval	**70**
17.7	Contracting/Tendering Procedure	**70**
17.7.1	Invitation to tender – Paper Based Process	**70**
17.7.2	Receipt and safe custody of tenders	**70**
17.7.3	Opening tenders and Register of tenders	**71**
17.7.4	Admissibility	**72**
17.7.5	Late tenders	**72**
17.7.6	Acceptance of formal tenders (See overlap with SFI No. 17.7)	**72**
17.7.7	Invitation to tender – Electronic Process	**73**
17.7.8	Tender reports to the Trust Board	**74**
17.8	Quotations: Competitive and Non-Competitive	**74**
17.8.1	General Position on quotations	**74**
17.8.2	Quotations	**74**
17.8.3	Quotations to be within Financial Limits	**74**
17.9	Authorisation of Tenders and Competitive quotations	**74**
17.10	Private finance for capital procurement (see overlap with SFI No. 24)	**75**
17.11	Compliance requirements for all contracts	**75**
17.12	Personnel and Agency or temporary staff contracts	**75**
17.13	Health Care Service Agreements (see overlap with SFI No. 18)	**75**
17.14	Disposals (see overlap with SFI No. 26)	**76**
17.15	In-house Services	**76**
17.16	Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 29)	**77**
18.	**NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES**	**77**
19.	**THIS SECTION IS NOT APPLICABLE TO NHS TRUSTS**	**78**
20.	**TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EMPLOYEES**	**78**

21.	**NON-PAY EXPENDITURE (see overlap with SFI No. 17)**	**80**
22.	**EXTERNAL BORROWING**	**83**
22.2	Investments	**83**
23.	**FINANCIAL FRAMEWORK**	**84**
24.	**CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS**	**89**
25.	**STORES AND RECEIPT OF GOODS**	**86**
26.	**DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS (See overlap with SFI 17)**	**90**
27	**INFORMATION TECHNOLOGY**	**92**
28.	**PATIENTS' PROPERTY**	**93**
29.	**FUNDS HELD ON TRUST**	**94**
30.	**ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT**	**95**
31.	**PAYMENTS TO INDEPENDENT CONTRACTORS**	**95**
32.	**RETENTION OF RECORDS**	**95**
33.	**RISK MANAGEMENT AND INSURANCE**	**95**

Version	Date	Comment
1	2010	
2	2012	
3	2013	Scheduled review: Updated to reflect the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation. Loss and compensation section updated. Delegated Limits reviewed.
4	October 2014	Scheduled review – Minor changes. Delegated limits reviewed.
5	October 2015	Scheduled review. Revised to reflect Capital Review Group Update to include revised process regarding centralisation of documents on the KC; improved escalation process and inclusion of a wider range of documents
6	June /July 2016	Scheduled review. Revised to ensure supports Board meeting moving to bi- monthly, include the Auditor Panel and strengthen procurement.

Equality Impact Assessment
This document has been reviewed in line with the Trust's Equality Impact Assessment guidance and no detriment was identified. This policy applies to all regardless of protected characteristic - age, sex, disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

Dissemination and Access
This document can only be considered valid when viewed via the East & North Hertfordshire NHS Trust Knowledge Centre. If this document is printed in hard copy, or saved at another location, you must check that it matches the version on the Knowledge Centre.

Associated Documentation
Gifts and Hospitality Policy
Conflicts of Interests Policy
Anti-Fraud and Bribery Policy
Trust Values & behaviours

Review
This document will be reviewed annually, or sooner in light of new legislation or new guidance issues by the department of Health.

Key messages

1. The consolidated document provides a single source of the key rules under which the Trust is managed and governed.
2. The regulations which determine the way that the Trust Board operates and the Trust is governed are spelt out in the Standing Orders.
3. Financial responsibilities and authorities are described in the SFIs and SoDA
4. All employees of the Trust need to be aware of their responsibilities and authorities described in this document. Non-compliance will result in investigation under the Trust Disciplinary Policy.

SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive or Company Secretary).

1.2 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

1.2.1 **Accountable Officer** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

1.2.2 **Trust** means the [name] of the Trust.

1.2.3 **Board** means the Chairman, officer and non-officer members of the Trust collectively as a body.

1.2.4 Bribery Act 2010 Where the Trust is engaged in commercial activity it could be considered guilty of a corporate bribery offence if an employee, agent, subsidiary or any other person acting on its behalf bribes another person intending to obtain or retain business or an advantage in the conduct of business for the Trust and it cannot demonstrate that it has adequate procedures in place to prevent such. The Trust does not tolerate any bribery on its behalf, even if this might result in a loss of business for it. Criminal liability must be prevented at all times. Appendix B is a summary of the Bribery Act 2010.

1.254 **Budget** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.2.6 **Budget holder** means the director of employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.2.7 **Chairman of the Board (or Trust)** is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression “the Chairman of the Trust” shall be deemed to include the Vice-Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

1.2.8 **Chief Executive** means the chief officer of the Trust.

1.2.9 **Clinical Governance Committee** means a committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the quality of healthcare for which the East and North Hertfordshire NHS Trust has responsibility.

1.2.10 **Commissioning** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

1.2.11 **Committee** means a committee or sub-committee created and appointed by the Trust.

1.2.12 **Committee members** means persons formally appointed by the Board to sit on or to chair specific committees.

1.2.13 **Contracting and procuring** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.2.14 **Director of Finance** means the Chief Financial Officer of the Trust.

1.2.15 **Funds held on trust** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

1.2.16 **Fraud** any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006. Appendix A is a summary of the Fraud Act 2006.

1.2.17 **Member** means officer or non-officer member of the Board as the context permits. Member in relation to the Board does not include its Chairman.

1.2.18 **Associate Member** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

1.2.19 **Membership, Procedure and Administration Arrangements Regulations** means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.

1.2.20 **Nominated officer** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.21 **Non-officer member** means a member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.

1.2.22 **Officer** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.23 **Officer member** means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chairman of the Trust or any person nominated by such a Committee for appointment as a Trust member).

1.2.24 **Secretary** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance.

1.2.25 **SFIs** means Standing Financial Instructions.

1.2.26 **SOs** means Standing Orders.

1.2.27 **Vice-Chairman** means the non-officer member appointed by the Board to take on the Chairman's duties if the Chairman is absent for any reason.

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The East and North Hertfordshire NHS Trust (the Trust) is a statutory body which came into existence on 1 April 2000 under The East and North Hertfordshire NHS Trust (Establishment) Order 2000 No 535, (the Establishment Order).

(1) The principal place of business of the Trust is Lister Hospital, Coreys Mill Lane, Stevenage, Hertfordshire, SG1 4AB.

(2) NHS Trusts are governed by statute mainly the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation.

(3) The statutory functions conferred on the Trust are set out in the NHS Act 2006 (Chapter 3 and schedule4) and in the Establishment Order.

(4) As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

(5) The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies. Furthermore the Trust has delegated powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation..

(6) The Code of Accountability for NHS Boards (DH, revised April 2013) requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

(7) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

(1) In addition to the statutory requirements the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.

(2) The Code of Accountability for NHS Boards (DH, revised April 2013) requires that, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Code of Conduct makes various requirements concerning possible conflicts of interest of Board members.

(3) The Code of Practice on Openness in the NHS as revised by the Freedom of Information Act 2000 and the Environmental Information Regulations 2004 sets out the requirements for public access to information on the NHS.

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). (See Section 1.8 and Appendix 2 of the Corporate Governance Framework Manual.) This document has effect as if incorporated into the Standing Orders. Delegated Powers are covered in a separate document entitled – 'Schedule of Matters reserved to the Board and Scheme of Delegation' and have effect as if incorporated into the Standing Orders and Standing Financial Instructions. The Standing Orders and Standing Financial Instructions will be reviewed annually

1.4 Integrated Governance

Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Guidance from the Department of Health on the move toward and implementation of integrated governance and other best practice guidance including the Healthy Board will continue to be incorporated in the Quality Governance and Risk Management Strategy. Integrated governance will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

In accordance with the Membership, Procedure and Administration Arrangements regulations the composition of the Board shall be:

(1) The Chairman of the Trust (Appointed by the NHS Appointments Commission/superseded by the Trust Development Authority in 2013 and NHS Improvement in 2016);

(2) Up to 5 non-officer members (appointed by the NHS Appointments Commission/superseded by the Trust Development Authority in 2013 and NHS Improvement in 2016);

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

- the Chief Executive;
- the Director of Finance;

The Trust shall have not more than 11 and not less than 8 members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

2.2 Appointment of Chairman and Members of the Trust

(1) Appointment of the Chairman and Members of the Trust - National Health Service Act 2006 as amended by the Health and Social Care Act provides that the

Chairman is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Chairman and members are set out in the Membership, Procedure and Administration Arrangements Regulations.

2.3 Terms of Office of the Chairman and Members

(1) The regulations setting out the period of tenure of office of the Chairman and members and for the termination or suspension of office of the Chairman 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-Chairman

(1) Subject to Standing Order 2.4 (2) below, the Chairman and members of the Trust may appoint one of their numbers, who is not also an officer member, to be Vice-Chairman, 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-Chairman by giving notice in writing to the Chairman. The Chairman and members may thereupon appoint another member as Vice-Chairman in accordance with the provisions of Standing Order 2.4 (1).

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

2.5 Joint Members

(1) Where more than one person is appointed jointly to a post mentioned in regulation 2(4)(a) of the Membership, Procedure and Administration Arrangements Regulations those persons shall count for the purpose of Standing Order 2.1 as one person.

(2) Where the office of a member of the Board is shared jointly by more than one person:

(a) either or both of those persons may attend or take part in meetings of the Board;

(b) if both are present at a meeting they should cast one vote if they agree;

(c) in the case of disagreements no vote should be cast;

(d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

2.6 Patient and Public Involvement

The Trust works with the local involvement network 'Healthwatch'. Healthwatch England was set up to make sure the views and experiences of consumers across the country are heard clearly by those who plan and run health and social care services and they are supported by legislation and a partner of the Care Quality Commission. Each local Healthwatch is

part of its local community and works in partnership with other local organisations.

2.7 Role of Members

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

(1) **Executive Members**

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

(2) **Chief Executive**

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

(3) **Director of Finance**

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4) **Non-Executive Members**

The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(5) **Chairman**

The Chairman shall be responsible for the operation of the Board and chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with the terms of appointment and with these Standing Orders.

The Chairman shall liaise with the NHS Improvement - Appointments ~~Commission~~ over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.8 Corporate role of the Board

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

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

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

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

2.9 Schedule of Matters reserved to the Board and Scheme of Delegation

(1) The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.10 Lead Roles for Board Members

The Chairman will ensure that the designation of Lead roles or appointments of Board members as required by the Department of Health or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

3. MEETINGS OF THE TRUST

3.1 Calling meetings

(1) Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

(2) The Chairman 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 Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three clear days before the meeting. The notice shall be signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.

(2) In the case of a meeting called by members in default of the Chairman 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 Chairman and Company Secretary at least 15 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chairman and Company Secretary.

(5) Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

3.3 Agenda and Supporting Papers

The Agenda will be sent to members 5 days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency.

3.4 Petitions

Where a petition has been received by the Trust the Chairman 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 Chairman.

(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 Chairman, 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 Chairman'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 Chairman of the meeting or any member present. It must also be seconded by another member.

ii) **Contents of motions**

The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

iii) **Amendments to motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

iv) **Rights of reply to motions**

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

v) **Withdrawing a motion**

A motion, or an amendment to a motion, may be withdrawn.

vi) **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion under Section I (2) or Section I (8) of the Public Bodies (Admissions to Meetings) Act I960 resolving to exclude the public, including the press (see Standing Order 3.17).

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chairman 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 Chairman 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 Chairman of meeting

(1) At any meeting of the Trust Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Vice-Chairman (if the Board has appointed one), if present, shall preside.

(2) If the Chairman and Vice-Chairman are absent, such member (who is not also an Officer Member of the Trust) as the members present shall choose shall preside.

3.10 Chairman's ruling

The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and members (including at least one member who is also an Officer Member of the Trust and one member who is not) is present.

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

(iii) If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

(i) Save as provided in Standing Orders 3.l3 - Suspension of Standing Orders and 3.l4 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chairman of the meeting shall have a second, and casting vote.

(ii) At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

(iii) If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

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

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

(vi) A manager who has been formally appointed to act up for an Officer Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Officer Member.

(vii) A manager attending the Trust Board meeting to represent an Officer Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member. An Officer's status when attending a meeting shall be recorded in the minutes.

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

3.13 Suspension of Standing Orders

(i) Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Officer Member of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

(ii) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and members of the Trust.

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

(iv) The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- upon a notice of motion under Standing Order 3.5;
- upon a recommendation of the Chairman 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 Chairman and Directors/members present at the meeting shall be recorded.

3.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

3.17 Admission of public and the press

(i) **Admission and exclusion on grounds of confidentiality of business to be transacted**

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Trust Board as follows:

- 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act l960

- *Guidance should be sought from the NHS Trust's Designated Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.*

(ii) **General disturbances**

The Chairman (or Vice-Chairman if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

- `That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act l960.

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

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

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

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

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.18 Observers at Trust meetings

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

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

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

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

4.2 Joint Committees

(i) Joint committees may be appointed by the Trust by joining together with one or more other ~~Trust Development Authority~~NHSI, CCG, or other Trusts consisting of, wholly or partly of the Chairman and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

(ii) Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term “Chairman” is to be read as a reference to the Chairman of other committee as the context permits, and the term “member” is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

4.4 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

4.6 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

4.8 Committees established by the Trust Board

The committees, sub-committees, and joint-committees established by the Board are:

4.8.1 **Audit Committee**

In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and more recently the Higgs report, an Audit Committee will be established and constituted to provide the Trust Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

The Higgs report recommends a minimum of three non-executive directors be appointed, unless the Board decides otherwise, of which one must have significant, recent and relevant financial experience.

4.8.2 **Remuneration and Terms of Service Committee**

In line with the requirements of the NHS Codes of Conduct and Accountability, and more recently the Higgs report, a Terms of Service and Remuneration Committee will be established and constituted.

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

The purpose of the Committee will be to advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors including:

(i) ~~(i)~~ setting the Remuneration Policy for the Chief Executive, Executive Directors and staff on Trust Pay

~~(i)~~(ii) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) ~~(iii)~~ arrangements for termination of employment and other contractual terms.

~~(ii)~~(iv) To review and approve the Remunerations Framework for subsidiary companies of the Trust.

4.8.3 **Trust and Charitable Trustee Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Trust Board will establish a Trust and Charitable Trust Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

The provisions of this Standing Order must be read in conjunction with Standing Order 2.8 and Standing Financial Instructions 29.

~~4.8.4~~

4.8.4 Other Committees

The Board may also establish such other committees as required to discharge the Trust's responsibilities. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

These currently include:

i) Finance and Performance Committee - The purpose Committee is to support the further development of the financial strategy of the Trust, to review the strategy as appropriate and monitor progress against it to ensure the achievement of financial targets and business objectives and the financial stability of the Trust. The Committee will also oversee aspects of the underpinning activity performance of the Trust, along with responsibility for the IM&T strategy transformation programme to improve data quality and hospital efficiency to ensure the Trust is prepared for forthcoming major financial challenges facing the NHS.

ii) Risk and Quality Committee - The purpose of the Committee will be to ensure that the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk. It is inclusive of clinical and corporate risk, clinical governance, clinical effectiveness, research governance, information governance, health & safety, staff governance and patient and public safety. The Committee will ensure that the Trust has an effective management and clinical governance framework which includes the assessment and monitoring of quality indicators which drive forward the development of quality of services and care, patient safety, patient experience and clinical outcomes and effectiveness.

iii) Auditor Panel

In line with the requirements of the Local Audit and Accountability Act 2014 an Auditor Panel will be established to enable the Trust to meet its statutory duties by advising on the selection, appointment and removal of the External Auditors and on maintaining an independent relationship with them. The Auditor Panel will ensure the 2017/18 appointment is made by 31st December 2016. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis. The committee be comprised Audit Committee Non-Executive Directors.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 The National Health Service Act 2006 as amended by the Health and Social Care Act 2012 allows for regulations to provide for the functions of Trust's to be carried out by third parties. In accordance with The Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 the functions of the Trust may also be carried out in the following ways:

(i) by another Trust;

(ii) jointly with any one or more of the following: NHS trusts, NHS Improvement ~~Trust Development Authority~~ (NHSI~~TDA~~) or Clinical Commissioning Group (CCGs) ;

(iii) by arrangement with the appropriate Trust or CCG, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;

(iv) in relation to arrangements made under S63(1) of the Health Services and Public Health Act 1968, jointly with one or more NHSI~~TDA~~, NHS Trusts or CCG.

5.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or officers, the Trust delegating the function retains full responsibility.

5.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two non-officer members. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

5.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.3.2 When the Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate

officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance to provide information and advise the Board in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

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

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The Trust Board will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by East and North Hertfordshire NHS Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct and Conflicts of Interest Policy for East and North Hertfordshire NHS Trust staff;

- the staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 2010;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 **Requirements for Declaring Interests and applicability to Board Members**

i) The NHS Code of Accountability requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

7.1.2 **Interests which are relevant and material**

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

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);

b) Shareholding of over 5% in any company operating in the same market as the Trust or with a substantial contract with the Trust;

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

d) A position of Authority in a charity or voluntary organisation in the field of health and social care;

e) Any connection with a voluntary or other organisation contracting for NHS services;

f) Research funding/grants that may be received by an individual or their department;

g) Interests in pooled funds that are under separate management.

h) Any relevant position held by a spouse, ~~or~~ partner or family member;

i) Any influence over recruitment, or management (or other oversight) over family members, close friends or spouse/partner

(ii) Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any

person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

7.1.3 **Advice on Interests**

If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Trust or with the Trust's Company Secretary.

International Financial Reporting Standard (IAS 24) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 **Recording of Interests in Trust Board minutes**

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes.

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

7.1.5 **Publication of declared interests in Annual Report**

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

7.1.6 **Conflicts of interest which arise during the course of a meeting**

During the course of a Trust Board or Board Committee meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (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 Chairman 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 Chairman 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 Chairman 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 Chairman or a Member by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

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

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

(1) Power of the Secretary of State to make waivers

Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a chairman 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 'Chairman' for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3.(3) (below), the "relevant chairman" is –

(a) at a meeting of the Trust, the Chairman of that Trust;

(b) at a meeting of a Committee –

(i) in a case where the member in question is the Chairman of that Committee, the Chairman of the Trust;

(ii) in the case of any other member, the Chairman 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 [name] Trust ("the Trust"), who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

(a) services under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation; or

(b) services in connection with a pilot scheme under the now the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation;

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

(ii) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:-

(a) arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(b) has been declared by the relevant chairman 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) <u>Conditions which apply to the waiver and the removal of having a pecuniary interest</u>

The removal is subject to the following conditions:

(a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant chairman must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3 (2) (b) above, except where that member is the Chief Executive;

(c) **in the case of a meeting of the Trust**:

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may not vote on any question with respect to it.

(d) **in the case of a meeting of the Committee:**

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may vote on any question with respect to it; but

(iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.4 Standards of Business Conduct

7.4.1 **Trust Policy and National Guidance**

All Trust staff and members of must comply with the Trust's Values and Standards of Business Conduct and Conflicts of Interest Policy and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff' (see SO 6.2).

7.4.2 **Interest of Officers in Contracts**

i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust's Company Secretary as soon as practicable.

ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 **Canvassing of and Recommendations by Members in Relation to Appointments**

i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4.4 **Relatives of Members or Officers**

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

ii) The Chairman 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 Chairman and members in proceedings on account of pecuniary interest' (SO 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him/her in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

8.3 **Register of Sealing**

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 **Signature of documents**

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

9. MISCELLANEOUS (see overlap with SFI No. 21.3)

9.1 **Joint Finance Arrangements**

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation.

See overlap with Standing Financial Instruction No. 21.3.

SECTION C - SCHEME OF RESERVATION AND DELEGATION

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
NA	THE BOARD	***Regulations and Control*** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 5.2 5. Approve a scheme of delegation of powers from the Board to committees. 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		Executive's attention in accordance with SO 5.6. 16. Discipline members of the Board or employees who are in breach of statutory requirements or SOs. 17. Approve the establishment of a subsidiary company and the associated articles of association and operating framework
NA	THE BOARD	**Appointments/ Dismissal** 1. Appoint the Vice Chairman of the Board. 2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2). 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders). 6. Approve proposals of the Remuneration Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration Committee.
NA	THE BOARD	***Strategy, Plans and Budgets*** 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment. 5. Approve budgets. 6. Approve annually Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a 3 year period or the period of the contract if longer. 11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		12. Approve individual compensation payments. 13. Approve proposals for action on litigation against or on behalf of the Trust. Review use of NHSLA risk pooling schemes (LPST/CNST/RPST).
	THE BOARD	**Policy Determination** 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. Policies so adopted shall be listed and held by the Company Secretary
	THE BOARD	**Audit** 1 Receipt of the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 2 Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
NA	THE BOARD	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for funds held on trust.
NA	THE BOARD	**Monitoring** 1. Receipt of such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board. 3. Receive reports from DoF on financial performance. 4. Receive reports from CE on performance matters by exception.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 11.1.1	AUDIT COMMITTEE	The Committee will act in accordance with the Audit Committee Handbook 2010, and: 1. Advise the Board on internal and external audit services; 2. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; 3. The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. 4. The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. 5 Monitor compliance with Standing Orders and Standing Financial Instructions; 6 Review schedules of losses and compensations and making recommendations to the Board. 7 Review the annual financial statements prior to submission to the Board. A full list of responsibilities can be viewed in the Terms of reference for this committee which are appended to this document
SFI 20.1.2	REMUNERATION AND TERMS OF SERVICE COMMITTEE (REMUNERATION COMMITTEE)	The Committee will: 1. Advise the Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees including: 2. All aspects of salary (including any performance-related elements/bonuses); 3. Provisions for other benefits, including pensions and cars; 4. Arrangements for termination of employment and other contractual terms; 5. Make recommendations to the Board on the remuneration and terms of service of executive directors and senior employees to ensure they are fairly rewarded for their individual contribution to the Trust -

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff; 6. Proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate advise on and oversee appropriate contractual arrangements for such staff; 7. 7. The Committee shall report in writing to the Board the basis for its recommendations. 7.8. Approve the Remuneration Framework for its subsidiaries. A full list of responsibilities can be viewed in the Terms of reference for this committee which are appended to this document
	RISK AND QUALITY COMMITTEE	The purpose of the Committee will be to ensure that the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk. It is inclusive of clinical and corporate risk, clinical governance, clinical effectiveness, research governance, financial risk, information governance, health & safety, staff governance and patient and public safety. Please note the Trust's Finance and Performance Committee will ensure the monitoring of financial risk, unless were there is potential impact or actual risk to quality identified; in these circumstances RAQC will provide scrutiny. The Committee will ensure that the Trust has an effective management and clinical governance framework which includes the assessment and monitoring of quality indicators which drive forward the development of quality of services and care, patient safety, patient experience and clinical outcomes and effectiveness. A full list of responsibilities can be viewed in the Terms of reference for the committee which are appended to this document
	FINANCE COMMITTEE	The purpose of the Finance and Performance Committee is to support the further development of the financial strategy of the Trust, to review the strategy as appropriate and monitor progress against it to ensure the achievement of financial targets and business objectives and the financial stability of the Trust. This will include:- • overseeing the development and maintenance of the Trust's medium and

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		long term financial strategy; • reviewing and monitoring financial plans and their link to operational performance; • overseeing financial risk management • scrutiny and approval of business cases and oversight of the capital programme • maintaining oversight of the finance function, key financial policies and other financial issues that may arise. ~~The Committee will also oversee aspects of the underpinning activity performance of the Trust, along with responsibility for the enabling IM&T strategy for the Trust. It will ensure the Trust is prepared for the forthcoming major changes including Our Changing Hospitals and Foundation Trust Status.~~ The Committee will also oversee aspects of the underpinning activity performance of the Trust, along with responsibility for the IM&T strategy transformation programme to improve data quality and hospital efficiency to ensure the Trust is prepared for forthcoming major financial challenges facing the NHS. A full list of responsibilities can be viewed in the Terms of reference for the committee which are appended to this document
	EXECUTIVE COMMITTEE	The Executive Committee is the executive decision making body of the Trust and is a forum for handling complex, major organisational issues. Its purpose is: • to oversee the effective operational management of the Trust, including achievement of the Trust strategy, statutory duties, NHS priorities, local targets and requirements. • to support the delivery of safe and high quality patient centred care • to direct and influence the Trust service strategies and other key service improvement strategies which impact on these, in accordance with the Trust overall vision, values and business strategy. • to manage and monitor clinical quality, finance performance and activity. It will ensure executive decision-making and sign-up to delivery through group and personal accountability. Each fortnight the Committee will meet as the Divisional Executive Committee in order to ensure engagement and decision making with the wider senior leadership across the organisation.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		The EC is a forum for handling complex, major organisational issues. It will work within the strategic framework agreed by the Trust Board and characterised by robust debate argued in the context of Trust Board strategy, NHS priorities, local targets and requirements, accompanied by relevant evidence. It will ensure executive decision-making and sign-up to delivery through group and personal accountability. The EC will act in the context of corporate governance and the Trust Board can be assured that relevant issues will be aired, whether or not decisions are taken by the EC and reported to the Board or recommendations are formulated by the EC and made by the Board. A full list of responsibilities can be viewed in the Terms of reference for the committee which are appended to this document
	FOUNDATION TRUST COMMITTEE	The Committee has overall responsibility for monitoring the Foundation Trust application programme and identifying the risks to achieving authorisation by Monitor within the agreed timetable. The Committee is also responsible for monitoring the Trust's compliance with the timeline agreed with the NHS Improvement Trust Development Authority and Trust Board. It is acknowledged that the Committee will not be required to meet whilst there is not an active timeline but will be reinstated when required. A full list of responsibilities can be viewed in the Terms of reference for the committee which are appended to this document
	CHARITY TRUSTEE COMMITTEE	The purpose of the Charity Trustee Committee is: • To ensure a robust strategy for delivery of the Charity aims and objectives • To champion the charity and its development, providing leadership both within the Trust and externally • To provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies This is a delegated duty carried out on behalf of the East and North Hertfordshire NHS Trust, which is the

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		sole *Corporate Trustee* of the charity, East & North Herts Hospitals (registered charity no 1053338). A full list of responsibilities can be viewed in the Terms of reference for the committee which are appended to this document
	AUDITOR PANEL	In line with the requirements of the Local Audit and Accountability Act 2014 the Auditor Panel was established in 2016 to enable the Trust to meet its statutory duties by advising on the selection, appointment and removal of the External Auditors and on maintaining an independent relationship with them. The Auditor Panel will ensure the 2017/18 appointment is made by 31st December 2016. A full list of responsibilities can be viewed in the Terms of reference for the committee which are appended to this document

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

REF	DELEGATED TO	DUTIES DELEGATED
1 & 5	**CHIEF EXECUTIVE & COMPANY SECRETARY**	**Review scheme of delegation**
7	CHIEF EXECUTIVE (CE)	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
9	CE AND DIRECTOR OF FINANCE (DOF)	Ensure the accounts of the Trust are prepared under principles and in a format directed by the SofS. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
10	CHIEF EXECUTIVE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
12 & 13	CHIEF EXECUTIVE	*Ensure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of corporate governance including ensuring managers:* • "have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
12	CHAIRMAN	Implement requirements of corporate governance.
13	CHIEF EXECUTIVE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the NHSI~~Audit Commission~~ and the National Audit Office (NAO).

REF	DELEGATED TO	DUTIES DELEGATED
15	DoF	Operational responsibility for effective and sound financial management and information.
15	CHIEF EXECUTIVE	Primary duty to see that DoF discharges this function.
16	CHIEF EXECUTIVE	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
18	CE and DoF	Chief Executive, supported by Director of Finance, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
19	CHIEF EXECUTIVE	If CE considers the Board or Chairman is doing something that might infringe probity or regularity, he/she should set this out in writing to the Chairman and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary the TDA NHSIand Department of Health.
21	CHIEF EXECUTIVE	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CE's responsibility for value for money, the CE should draw the relevant factors to the attention of the Board. If the outcome is that he/she is overruled it is normally sufficient to ensure that his/her advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CE should inform the NHSITrust Development Authority and the DH. In such cases, and in those described in paragraph 24, the CE should as a member of the Board vote against the course of action rather than merely abstain from voting.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.1.7	BOARD	Approve procedure for declaration of hospitality and sponsorship.
1.3.1.8	BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
1.31.9 & 1.3.2.2	ALL BOARD MEMBERS	Subscribe to Code of Conduct, ~~and~~ Trust Values and coaching culture.
1.3.2.4	BOARD	Board members share corporate responsibility for all decisions of the Board.
1.3.2.4	CHAIR AND NON EXECUTIVE/OFFICER MEMBERS	Chair and non-officer members are responsible for monitoring the executive management of the organisation and are responsible to the SofS for the discharge of those responsibilities.
1.3.2.4	BOARD	The Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
1.3.24	BOARD	It is the Board's duty to:

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these, 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; 4. establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.
1.3.2.5	CHAIRMAN	It is the Chairman's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board; 7. advise the Secretary of State on the performance of Non-Executive Board members.
1.3.2.5	CHIEF EXECUTIVE	The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		Memorandum.
1.3.2.6	NON EXECUTIVE DIRECTORS	Non-Executive Directors are appointed by NHSI – Appointments Appointments Commission to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
1.3.2.8	CHAIR AND DIRECTORS	Declaration of conflict of interests.
1.3.2.9	BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SCHEME OF DELEGATION FROM STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	CHAIRMAN	Final authority in interpretation of Standing Orders (SOs).
2.4	BOARD	Appointment of Vice Chairman
3.1	CHAIRMAN	Call meetings.
3.9	CHAIRMAN	Chair all Board meetings and associated responsibilities.
3.10	CHAIRMAN	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIRMAN	Having a second or casting vote
3.13	BOARD	Suspension of Standing Orders
3.13	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.14	BOARD	Variation or amendment of Standing Orders
4.1	BOARD	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Chief Executive.)
5.2	CHAIRMAN & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	THE BOARD	Declare relevant and material interests.
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
7.4	ALL STAFF	Comply with national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff” and Trust Values.
7.4	ALL	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
8.1/8.3	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
8.4	CHIEF EXECUTIVE/EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	DIRECTOR OF FINANCE	Approval of all financial procedures.
10.1.4	DIRECTOR OF FINANCE	Advice on interpretation or application of SFIs.
10.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
10.2.3	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.3	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.4	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.5	DIRECTOR OF FINANCE	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust’s transactions and financial position; d) Providing financial advice to members of Board and staff; e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
10.2.7	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.2.8	Director of Finance	All members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.
11.1.1	Audit Committee	Provide independent and objective view on internal control and probity.
11.1.2	Chair	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 & 11.2.1	Director of Finance	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
11.2.1	Director of Finance	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
11.3	Head of Internal Audit	Review, appraise and report in accordance with Public Sector Internal Audit Standards ~~NHS Internal Audit Manual~~ and best practice.
11.4	Audit Committee	Ensure cost-effective External Audit.
11.5	Chief Executive & Director of Finance	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
11.6	Chief Executive	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
13.1.1	Chief Executive	Compile and submit to the Board an delivery plan which takes into account financial targets and forecast limits of available resources. The plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
13.1.2 & 13.1.3	Director of Finance	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
13.1.4	DIRECTOR OF FINANCE	All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.
13.1.5	BUDGET HOLDERS	All budget holders will sign up to their allocated budgets at the commencement of each financial year.
13.1.6	DIRECTOR OF FINANCE	Ensure adequate training is delivered on an on going basis to budget holders.
13.3.1	CHIEF EXECUTIVE	Delegate budget to budget holders.
13.3.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
13.4.1	DIRECTOR OF FINANCE	Devise and maintain systems of budgetary control.
13.4.2	BUDGET HOLDERS	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment.
13.4.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the Annual Plan.
13.6.1	CHIEF EXECUTIVE	Submit monitoring returns
14.1	DIRECTOR OF FINANCE	Preparation of annual accounts and reports.
15.1	DIRECTOR OF FINANCE	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
16.	DIRECTOR OF FINANCE	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
16.2.3	ALL EMPLOYEES	Duty to inform DoF of money due from transactions which they initiate/deal with.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.	CHIEF EXECUTIVE	Tendering and contract procedure.
17.5.3	CHIEF EXECUTIVE	Waive formal tendering procedures.
17.5.3	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Board.
17.5.5	DIRECTOR OF FINANCE	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.
17.6.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders received.
17.6.3	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations despatched.
17.6.4	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Where one tender is received will assess for value for money and fair price.
17.6.6	CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.6.8	CHIEF EXECUTIVE	Will appoint a manager to maintain a list of approved firms.
17.6.9	CHIEF EXECUTIVE	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
17.7.2	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
17.7.4	CHIEF EXECUTIVE or DIRECTOR OF FINANCE	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.10	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
17.10	BOARD	All PFI proposals must be agreed by the Board.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.11	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
17.12	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
17.15	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
17.15.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
18.1.1	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
18.3	CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA
20.1.1	BOARD	Establish a Remuneration & Terms of Service Committee
20.1.2	REMUNERATION COMMITTEE	Advise the Board on and make recommendations on the remuneration and terms of service of the CE, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
20.1.3	REMUNERATION COMMITTEE	Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.
20.1.4	BOARD	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
20.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
20.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.4.1 and 20.4.2	DIRECTOR OF FINANCE	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 10.4.2).
20.4.3	NOMINATED MANAGERS*	Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time.
20.4.4	DIRECTOR OF FINANCE	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
20.5	NOMINATED MANAGER*	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
21.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. Authorised signatory list is maintained by the finance Department and available on request
21.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
21.2.1	REQUISITIONER*	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
21.2.2	DIRECTOR OF FINANCE	Shall be responsible for the prompt payment of accounts and claims.
21.2.3	DIRECTOR OF FINANCE	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
21.2.4	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
21.2.4	DIRECTOR OF FINANCE	Approve proposed prepayment arrangements.
21.2.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform DoF if problems are encountered).
21.2.5	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
21.2.6	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
21.2.7	CHIEF EXECUTIVE DIRECTOR OF FINANCE	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
21.3	DIRECTOR OF FINANCE	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
22.1.1	DIRECTOR OF FINANCE	The DoF will advise the Board on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts.
22.1.2	BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the CE and DoF.)
22.1.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions concerning applications for loans and overdrafts.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
22.1.4	CHIEF EXECUTIVE OR DIRECTOR OF FINANCE	Be on an authorising panel comprising one other member for short term borrowing approval.
22.2.2	DIRECTOR OF FINANCE	Will advise the Board on investments and report, periodically, on performance of same.
22.2.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions on the operation of investments held.
23	DIRECTOR OF FINANCE	Ensure that Board members are aware of the Financial Framework and ensure compliance
24.1.1 & 2	CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.
24.1.2	DIRECTOR OF FINANCE	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
24.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
24.1.4	DIRECTOR OF FINANCE	Assess the requirement for the operation of the construction industry taxation deduction scheme.
24.1.5	DIRECTOR OF FINANCE	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
24.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
24.1.7	DIRECTOR OF FINANCE	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
24.2.1	DIRECTOR OF FINANCE	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
24.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.
24.3.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from DoF).
24.3.5	DIRECTOR OF FINANCE	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
24.3.8	DIRECTOR OF FINANCE	Calculate and pay capital charges in accordance with Department of Health requirements.
24.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
24.4.2	DIRECTOR OF FINANCE	Approval of fixed asset control procedures.
24.4.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
25.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
25.2	DIRECTOR OF FINANCE	Responsible for systems of control over stores and receipt of goods.
25.2	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks
25.2	DESIGNATED ESTATES OFFICER	Responsible for control of stocks of fuel oil and coal.
25.2	NOMINATED OFFICERS*	Security arrangements and custody of keys
25.2	DIRECTOR OF FINANCE	Set out procedures and systems to regulate the stores.
25.2	DIRECTOR OF FINANCE	Agree stocktaking arrangements.
25.2	DIRECTOR OF FINANCE	Approve alternative arrangements where a complete system of stores control is not justified.
25.2	DIRECTOR OF FINANCE	Approve system for review of slow moving and obsolete items and for condemnation, disposal and

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		replacement of all unserviceable items.
25.2	NOMINATED OFFICERS*	Operate system for slow moving and obsolete stock, and report to DoF evidence of significant overstocking.
25.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supply Chain.
26.1.1	DIRECTOR OF FINANCE	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
26.2.1	DIRECTOR OF FINANCE	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
26.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and DoF.
26.2.2	DIRECTOR OF FINANCE	Where a criminal offence is suspected, DoF must inform the police if theft or arson is involved. In cases of fraud and corruption DoF must inform the relevant LCFS and NHS Protect Regional Team in line with SoS directions.
26.2.2	DIRECTOR OF FINANCE	Notify NHS Protect and External Audit of all frauds.
26.2.3	DIRECTOR OF FINANCE	Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
26.2.4	BOARD	Approve write off of losses (within limits delegated by DH).
26.2.6	DIRECTOR OF FINANCE	Consider whether any insurance claim can be made.
26.2.7	DIRECTOR OF FINANCE	Maintain losses and special payments register.
27.1	DIRECTOR OF FINANCE	Responsible for accuracy and security of computerised financial data.
27.1	DIRECTOR OF FINANCE	Satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
27.1.3	COMPANY SECRETARY	Shall ensure that a Freedom of Information Scheme is published and maintained.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
27.2.1	RELEVANT OFFICERS	Send proposals for general computer systems to DoF
27.3	DIRECTOR OF FINANCE	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
27.4	DIRECTOR OF FINANCE	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
27.5	DIRECTOR OF FINANCE	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) DoF and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
28.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
28.3	DIRECTOR OF FINANCE	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
28.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
29.1	DIRECTOR OF FINANCE	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
30	DIRECTOR OF FINANCE	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
32	CHIEF EXECUTIVE	Retention of document procedures in accordance with HSC 1999/053.
33.1	CHIEF EXECUTIVE	Risk management programme.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
33.1	BOARD	Approve and monitor risk management programme.
33.2	BOARD	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
33.4	DIRECTOR OF FINANCE	Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
33.4	DIRECTOR OF FINANCE	Ensure documented procedures cover management of claims and payments below the deductible.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

SECTION D - STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

10.1 General

10.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

10.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

10.1.5 **The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

10.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Performance and Finance as soon as possible.

10.2 Responsibilities and delegation

10.2.1 **The Trust Board**

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

10.2.2 The Board secretary holds a record of circumstances that the Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. All other powers have been delegated to such other committees as the Trust has established.

10.2.3 **The Chief Executive and Director of Finance**

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

10.2.4 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.5 **The Director of Finance**

The Director of Finance is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

10.2.6 **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.7 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

10.2.8 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.

11. AUDIT

11.1 Audit Committee

11.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2010), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

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

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

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

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

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

11.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health. (To the Director of Finance in the first instance.)

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

11.2 Director of Finance

11.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(e) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

11.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

11.3 Role of Internal Audit

11.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust’s assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;

(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health.

11.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

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

11.3.4 The audit manager shall be accountable to the Audit Committee though the Head of Internal Audit and shall report to the Director of Finance for the operational delivery. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the audit manager. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every three years.

11.4 External Audit

11.4.1 The External Auditor wasis appointed by the Audit Commission and is paid for by the Trust. As the Audit Commission closed on 1 April 2015 this contract is managed by a 'transitional body', Public Sector Audit Appointments Ltd. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Public Sector Audit Appointments Ltd ~~Audit Commission~~ if the issue cannot be resolved. From 2017/18 onwards, NHS Trusts must have an 'Auditor Panel' to advise on the selection, appointment and removal of their External Auditors and on maintaining an independent relationship with them.

11.5 Fraud and Corruption

11.5.1 In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with the Health and Social Care Act 2012.

11.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

11.5.3 The Local Counter Fraud Specialist shall report to the Trust Director of Finance and shall work with staff in the NHS Protect and the Regional Counter Fraud in accordance with the Department of Health Fraud and Corruption Manual.

11.5.4 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

11.6 Security Management

11.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

11.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

12. RESOURCE LIMIT CONTROL

The Chief Executive as accountable officer and Finance Director as accounting officer are responsible for controls that ensure the Trust operates within resource limits set by the Department of Health or ~~TDA~~NHSI.

13. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

13.1 Preparation and Approval of Plans and Budgets

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

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

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

13.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Plan

(b) accord with workload and manpower plans;

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

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

(e) identify potential risks.

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

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

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

13.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

13.3 Budgetary Delegation

13.3.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

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

13.3.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

13.3.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

13.4 Budgetary Control and Reporting

13.4.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) Movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

13.4.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

13.4.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Trust's plans and a balanced budget.

13.5 Capital Expenditure

13.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 24).

13.6 Monitoring Returns

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

14. ANNUAL ACCOUNTS AND REPORTS

14.1 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and generally accepted accounting practice;

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

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

14.2 The Trust's annual accounts must be audited by an auditor appointed by the Audit Commission (Currently managed by a 'transitional body', Public Sector Audit Appointments Ltd). The Trust's audited annual accounts must be presented to a public meeting and made available to the public. From 2017/18 onwards, NHS Trusts must have an 'Auditor Panel' to advise on the selection, appointment and removal of their External Auditors and on maintaining an independent relationship with them.

14.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Manual for Accounts.

15. BANK AND GBS ACCOUNTS

15.1 General

15.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This may include operating through a shared business service. It will take into account guidance/ Directions issued from time to time by the Department of Health. In line with 'Cash Management in the NHS' Trusts should minimize the use of commercial bank accounts and consider using Government Banking service accounts for all banking services.

15.1.2 The Board shall approve the banking arrangements.

15.2 Bank and GBS Accounts

15.2.1 The Director of Finance is responsible for:

(a) bank accounts and Office of the Paymaster General (GBS) accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

(e) monitoring compliance with DH guidance on the level of cleared funds.

15.3 Banking Procedures

15.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

(c) the use of shared business service.

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

15.4 Tendering and Review

15.4.1 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

15.4.2 Competitive tenders should be considered at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

16. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

16.1 Income Systems

16.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

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

16.2 Fees and Charges

16.2.1 The Trust shall follow the Department of Health's advice in the "Costing" Manual in setting prices for NHS service agreements and comply with Department of Health set price tariffs.

16.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

16.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

16.3 Debt Recovery

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

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

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

16.4 Security of Cash, Cheques and other Negotiable Instruments

16.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

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

16.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

16.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

16.5 2003 Money Laundering Regulations

Under no circumstances will the Trust accept cash payments in excess of 15,000 Euros (converted to sterling at the prevailing rate at the time) in respect of any single transaction. Any attempt to effect payment above this amount should be immediately notified to the Director of Finance.

17. TENDERING AND CONTRACTING PROCEDURE

17.1 General

The Trust shall use Hertfordshire NHS Procurement for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented. If the Trust does not use Hertfordshire NHS Procurement the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

17.2 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

17.3 EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

17.4 Reverse eAuctions

Reverse eAuctions will be conducted in accordance with Trust policy and procedures in place for the control of all tendering activity carried out through this process.

17.5 Capital Investment Manual and other Department of Health Guidance

The Trust shall comply as far as is practicable with the requirements of the Department of Health "Capital Investment Manual" and “Estate code” in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance "The Procurement and Management of Consultants within the NHS".

17.6 Formal Competitive Tendering

17.6.1 **General Applicability**

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

17.6.2 **Health Care Services**

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 18 and No. 19.

17.6.3 **Exceptions and instances where formal tendering need not be applied**

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the amounts set out in the procurement scheme of delegation. (see appendix to this report)

(b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No. 25;

(d) where a national or regional arrangement is in place: CCS Crown Commercial Service framework agreements, collaborative procurement hub contracts, NHS Supply Chain framework and local agreements arranged through Hertfordshire NHS Procurement.

Formal tendering procedures **may be waived** in the following circumstances:

(e) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(f) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(g) where specialist expertise is required and is available from only one source;

(h) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(i) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(j) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(k) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record endorsed in accordance with the Trust's procurement scheme of delegation.

17.6.4 **Building and Engineering Construction Works**

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health approval.

17.6.5 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

17.7 Contracting/Tendering Procedure

17.7.1 **Invitation to tender – Paper Based Process**

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

(a)Submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

17.7.2 **Receipt and safe custody of tenders**

The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the e-tendering System or endorsed on the unopened tender envelope/package.

17.7.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive and not from the originating department.

(ii) The Buyer will send a notification of tender form indicating companies who have submitted together with costs and the successful bidder to the Chief Executive Office for recording in the Trust's register.

(iii) A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above £1m. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

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

(v) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(vi) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The Company Secretary will count as a Director for the purposes of opening tenders.

(vii) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(viii) A register shall be maintained by the Chief Executive, or a person authorised by him, to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(ix) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Order No. 17.6.5 below).

17.7.4 **Admissibility**

(i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

17.7.5 **Late tenders**

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

17.7.6 **Acceptance of formal tenders (See overlap with SFI No. 17.7)**

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(ii) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection.

17.7.7 Invitation to tender – Electronic Process

(i) All tenders will be undertaken through the Due North electronic tendering system. This shall enable: The required levels of calls for competition; a supplier information database; a process to request for prequalification information; evaluation of expressions of interest & prequalification questionnaires; creation of quotation/tender documents; invitation to tender; receipt of tenders; opening procedures evaluation award; contract management; and archiving of tender documentation

(ii) Tenders will be returned to an „electronic safe and locked until the due date for the receipt of bids from invited suppliers. As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by the Head of Procurement (Hertfordshire NHS Procurement) as the Chief Executive nominated representative. Should the Head of Procurement (Hertfordshire NHS Procurement) not be available, the task may be further delegated to a Hertfordshire NHS Procurement staff member trained in the use of Due North and otherwise not involved in the tender exercise.

(iii) The Head of Procurement (Hertfordshire NHS Procurement) as guardian for the Due North system is responsible for ensuring all tenders are treated as confidential and retained for inspection. The system provides a register of: the name of all firms or individuals invited to tender; the names of firms or individuals from which tenders have been received; the date the tenders were opened; and the price shown on each tender.

(iv) There is generally no discretion to receive tenders after the due date. In exceptional circumstances the Head of Procurement (Hertfordshire NHS Procurement) may request the Chief Executive approve the inclusion of a late tender. The request will include an explanation of the exceptional circumstance and assurance that the tender process has not been compromised.

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

Where only one tender is sought and/or received, the Chief Executive and Finance Director shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

Any discussions with a tenderer which are deemed necessary to clarify technical aspects of the tender before the award of a contract will not disqualify the tender.

The most economically advantageous tender shall be accepted as determined by the tender evaluation criteria set by the tender project team at the start of the tender process.

No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Executive. The use of these procedures must demonstrate that the award of the contract was not in excess of the going market rate / price current at the time the contract was awarded; and that best value for money was achieved.

(vi) The Head of Procurement (Hertfordshire NHS Procurement) as the Chief Executive nominated officer responsible for tendering will report to the Trust Board on an exceptional circumstance basis as required by the Chief Executive.

17.7.8 **Tender reports to the Trust Board**

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

17.8 Quotations: Competitive and non-competitive

17.8.1 **General Position on quotations**

Quotations are required where formal tendering procedures are not adopted because the intended expenditure or income does not exceed the amounts set out in the scheme of delegation.

17.8.2 **Quotations**

(i) Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(ii) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(iii) All quotations should be treated as confidential and should be retained for inspection.

(iv) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

17.8.3 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

17.9 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a

contract may be decided by the staff as set out in the Trusts' procurement scheme of delegation (as per appendix 1 to this report).

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

17.10 Private Finance for capital procurement (see overlap with SFI No. 24)

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

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

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.

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

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

17.11 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

17.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

17.13 Healthcare Services Agreements (see overlap with SFI No. 18)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

17.14 Disposals (See overlap with SFI No. 26)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the procurement policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

17.15 In-house Services

17.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

17.15.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a procurement officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £1m, a non-officer member should be a member of the evaluation team.

17.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

17.15.4 The evaluation team shall make recommendations to the Board.

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

17.16 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 29)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

18. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 17.13)

18.1 Service Level Agreements (SLAs)

18.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within future plans and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

18.2 Involving Partners and jointly managing risk

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

18.3 Commissioning

NHS England has published Putting Patients First to deliver high quality care for all, now and for future generations and this sets out the commissioning upon which the Government's major reform agenda will be carried forward in line with the National Health Service Act 2006 as amended by the Health and Social Care Act 2012. The latest guidance can be accessed on www.england.nhs.uk

18.4 Reports to Board on SLAs

The Chief Executive, as the Accountable Officer, will ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for

specific services, all parties should agree a common currency for application across the range of SLAs.

19. THIS SECTION IS NOT APPLICABLE TO NHS TRUSTS

20. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

20.1 Remuneration and Terms of Service (see overlap with SO No. 4)

20.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

20.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other officer members employed by the Trust and other senior employees including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of officer members of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members (and other senior employees);

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

(e) Agree the framework or broad policy for remuneration for Directors of the subsidiary

20.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

20.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

20.1.5 The Trust will pay allowances to the Chairman and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health.

20.2 **Funded Establishment**

20.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

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

20.3 Staff Appointments

20.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive or delegated relevant Director;

(b) within the limit of their approved budget and funded establishment.

20.3.2 20.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

20.4 Processing Payroll

20.4.1 The Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

20.4.2 The Director of Finance will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(I) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

20.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

20.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

20.5 Contracts of Employment

20.5.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

21. NON-PAY EXPENDITURE

21.1 Delegation of Authority

21.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

21.1.2 The Chief Executive will set out:

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

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

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

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

21.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's procurement department (Hertfordshire NHS Procurement) shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

21.2.2 **System of Payment and Payment Verification**

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

21.2.3 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Board employees authorised to certify invoices.

(ii) A process of electronic certification.

(iii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iv) A process for prompt submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(v) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.4 below.

21.2.4 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

21.2.5 **Official orders**

Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

21.2.6 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

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

(d) with regard to the Bribery Act 2010 no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 6 and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff");

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

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

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

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

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

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

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

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

21.2.7 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

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

21.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act **shall** comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

22. EXTERNAL BORROWING

22.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

22.1.2 The Finance Director will maintain a list of employees (including specimens of their signatures) who are authorised to make short-term borrowings on behalf of the Trust.

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

22.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health.

22.1.5 Any short-term borrowing must be with the authority of two members of an authorised signatory list. The Board must be made aware of all short-term borrowings at the next Board meeting.

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

22.2 INVESTMENTS

22.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

22.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

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

23. FINANCIAL FRAMEWORK

23.3.1 The Director of Finance should ensure that members of the Board are aware of the Financial Framework. The Trust's medium term and longer-term financial strategy, the planned sources of funding including any external borrowing and repayment plan.

24. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

24.1 Capital Investment

24.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges;

(d) shall ensure that there is consultation with commissioners regarding capital investment of a strategic nature, or which has a material affect on income streams

24.1.2 For every capital expenditure proposal (other than those described in 24.1.4 and 24.1.5 below) the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual*) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

24.1.3.1 Investment Committee (reports to the FPC through the Director of Finance)

(a) sets the Trust's Annual Capital Programme and submits it to the Finance and Performance Committee for approval;

(b) considers all capital expenditure proposals within the parameters of the Capital Programme approved by the Finance and Performance Committee (FPC). Has authority to approve schemes up to £500,000 with schemes above this limit being referred to the FPC.

24.1.4 Capital Review Control Group, (reports to the FPC through the Director of Finance report)), meets on a monthly basis and performs the following functions:

(a) monitors progress of capital projects against budget;

(b) reports to the FPC on progress made on capital projects after each meeting

(c) liaises with Divisions and Project Sponsors to aid the progression and management of capital schemes

(d) monitors the procurement of donated assets valued over £100k and reports to the Charity Trustee Committee

(e) review all capital risks at the Trust

(f) ensures that the Capital Resource Limit (CRL is achieved at the Trust

(g) to review assets held at the Trust ensuring that the Trust Asset register is accurate.

24.1.4 Business cases presented to the Investment Committee and Capital Review Group should consider the use of lease funding. The Trust uses Leaseguard Group Limited to support the management of its lease portfolio. All lease proposals must be organised by Leaseguard unless the Finance and Performance Committee specifically agree alternative arrangements. Leaseguard's recommendations will be reviewed by the user department and

by Finance, but lease agreements can only be authorised in accordance with the Trust's Authorised Signatories for Lease Documentation.

24.1.5 On an annual basis the Director of Operations organises medical equipment capital requests from the Clinical Divisions which are considered at a special Divisional Operations Committee meeting at which applications are considered for inclusion on the Annual Capital Programme. A schedule of approved bids will prepared for review and final approval by the Medical and/or Nursing Director and the Investment Committee . 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

24.1.6 On an annual basis, the Head of Estates produces a schedule of backlog maintenance priorities using risk-based criteria. The schedule will be prepared for review and final approval at Investment Committee.

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

24.1.8 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

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

24.1.10 The Director of Finance’s report to the Finance and Performance Committee will detail major variations to the annual capital expenditure programme

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

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

(a) specific authority to commit expenditure;

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

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

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust’s Standing Orders.

24.1.12 The Finance and Performance Committee will evaluate, scrutinise and approve individual investment decisions including a review of Outline and Full Business Cases where there is:

(a) a capital scheme (including leased assets) with an investment value in excess of £500k

(b) all proposed fixed asset disposals where the value of the asset exceeds £500k

Where the scheme in question is in excess of £1 million, the Finance and Performance Committee will make a recommendation to the Trust Board, who will ultimately make a decision on the proposal

24.1.13 Where capital schemes are in excess of the Trust's delegated limits, they will require ~~TDA~~ NHSI approval.

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

24.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

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

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.

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

24.3 Asset Registers

24.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

24.3.2 The minimum data set to be held within the Trust's register shall be sufficient to identify, locate and value assets appropriately.

24.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) Notification of project completion by the relevant project manager who is responsible for ensuring properly authorized and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties.

(b) Purchase and installation of equipment.

(c) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(d) lease agreements in respect of assets held under a finance lease and capitalised.

24.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate) that are the responsibility of the relevant budget-holder.

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

24.3.6 The value of each asset shall be measured at its fair value in accordance with Trust's accounting policies.

24.3.7 The value of each asset shall be depreciated using methods and rates as specified to reflect the consumption of the assets economic useful life in accordance with the Trust's accounting policies.

24.3.8 The Director of Finance of the Trust shall calculate and pay a dividend based the required return on assets in accordance with department of Health accounting policies, currently set at 3.5%.

24.4 Security of Assets

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

24.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

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

24.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

24.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

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

25. STORES AND RECEIPT OF GOODS

25.1 General position

25.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

25.2 Control of Stores, Stocktaking, condemnations and disposal

25.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any

Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

25.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

25.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

25.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

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

25.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 25 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

25.3 Goods supplied by NHS Supply Chain

25.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note. Any discrepancies should be reported to NHS Supply Chain. The Director of Finance shall satisfy himself that the goods have been received before accepting the recharge.

26. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

26.1 Disposals and Condemnations

26.1.1 **Procedures**

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

26.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

26.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the

countersignature of a second employee authorised for the purpose by the Director of Finance.

26.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

26.2 Losses and Special Payments

26.2.1 **Procedures**

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

26.2.2 Any employee or officer discovering or suspecting a loss of any kind must refer to the Trust's Anti-Fraud and Bribery Policy and either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant LCFS and NHS Protect regional team in accordance with Secretary of State for Health's Directions.

The Director of Finance must notify the Counter Fraud and Security Management Services (NHS Protect) and the External Auditor of all frauds.

26.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Board,

(b) the External Auditor.

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

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

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

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

26.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

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

26.2.10 The Financial Controller and the Deputy Director of Finance are the nominated officers authorised by the Director of Finance to approve requests to write off bad debts up to the limit of £3,000 and £15,000 per invoice respectively. Requests to write off invoices in excess of £15,000 require the approval of the Director of Finance. All bad debts written off must be reported to the next meeting of the

Losses and Special Payments Committee, which must report to the Audit Committee on a twice-yearly basis.

26.2.11 Under delegated powers the Losses and Special Payments Committee can approve payments to patients, staff and members of the public in respect of approved personal propery claims of up to £3,000 without recourse to the Director of Finance. These claims will form part of the twice-year report to Audit Committee.

27. INFORMATION TECHNOLOGY

27.1 Responsibilities and duties of the Director of Finance

27.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

27.1.2 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

27.1.3 The Company Secretary shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

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

27.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

27.3 Contracts for Computer Services with other health bodies or outside agencies

The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

27.4 Risk Assessment

The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

27.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

28. PATIENTS' PROPERTY

28.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

28.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; ***(notices are subject to sensitivity guidance)***
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

28.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

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

28.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

28.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

28.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

29. FUNDS HELD ON TRUST

29.1 Corporate Trustee

(1) Standing Order No. 2.8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SFI 4.9.3 that defines the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

29.2 Accountability to Charity Commission and Secretary of State for Health

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

(2) The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

29.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 17.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

30. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Director of Finance shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

31. PAYMENTS TO INDEPENDENT CONTRACTORS

Not applicable to NHS Trust's

32. RETENTION OF RECORDS

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

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

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

33. RISK MANAGEMENT AND INSURANCE

33.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;
e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance ~~Statement~~ on the effectiveness

of Internal Control ~~(SIC)~~ within the Annual Report and Accounts as required by current Department of Health guidance.

33.2 Insurance: Risk Pooling Schemes administered by NHSLA

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

33.3 Insurance arrangements with commercial insurers

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

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

(2) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

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

(1) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

COMPETITION - SUPPLIES AND SERVICES

		For total estimated value of trust expenditure over the purchasing agreement period (exc vat) of:			
	SFI ref	**< £10,000**	**> £10,000 and < £50,000**	**> £50,000 and < £106,047 (OJEU limit)**	**> £106,047 (OJEU limit)**
Procedure		No formal procedure	Written requests for quotations issued by Procurement	Formal tenders issued by Procurement	OJEU tenders issued by Procurement
		Purchases should be made against existing national or local purchasing agreements where applicable Competition not required if expenditure is against existing national or local purchasing agreement. Tenders over £1m Board member to be present at tender opening (except e-tendering where this will done by Head of Procurement)			
Waiver		*Not applicable*	Approved by HOP	Endorsed by HOP, approved by DF, CE or DDF (in the absence of DF)	Waiver not permissible
Selection requirements		Best value obtained	Minimum 3 written quotes requested and returned	Sufficient to ensure fair competition. In no case less than 4 issued and 3 returned.	Compliant with OJEU procedures on advice from Procurement
Receipt of offers		Offers to budget holder or nominated deputy	Offers returned to Procurement HOP manages offer receipt and opening procedures including e-procurement	Offers returned to Procurement HOP manages offer receipt and opening procedures including e-procurement	Offers returned to CE office Secretary to Trust Board manages receipt and opening procedures under advice of HOP (Over £1m member of Board to be present)
Acceptance		Budget holder or nominated deputy	Lowest or within Financial Limit and reason for selection on basis of value for money documented	Lowest or within Financial Limit and reason for selection on basis of value for money documented	Lowest - or approval by DF and CE and reported to Board (subject to approvals in line with delegated limits for capital investment)
Signing purchase agreements		Endorsed by HOP signed by GM		Endorsed by HOP signed by DF or CE	
Records		Budget holder must be able to justify actions taken and demonstrate best value	Quotations register maintained by Procurement	Hard copy tenders register maintained by Secretary to Trust Board. Electronic tenders are recorded on Due North system	
			Retention of documents managed by Procurement		

Key:				
	CE = Chief Executive	DF = Director of Finance	GM =General Manager/Divisional Director	HOP = Head of Procurement
	Procurement = Hertfordshire NHS Procurement		DE = Director of Strategic Estates	DDF = Deputy Director of Finance

COMPETITION - CONSTRUCTION AND WORKS

	For total estimated value of trust expenditure over the purchasing agreement period (exc vat) of:					
	SFI ref	**< £5,000**	**> £5,000 and < £50,000**	**> £50,000 and < £1,000,000**	**> £1,000,000 and < £4,104,394 (OJEU Limit)**	**> £4,104,394 (OJEU Limit)**
Procedure		No formal procedure	Written requests for quotations issued by Capital Team or Estates	Formal tenders issued by Capital Team or Estates	Formal tenders issued by Capital Team or Estates	OJEU tenders issued by Capital Team or Estates
		Purchases should be made against existing national or local purchasing agreements where applicable Competition not required if expenditure is against existing national or local purchasing agreement				
Waiver		*Not applicable*	Endorsed by HC/HE, approved by DE	Approved by DE and DF or CE	Recommended by DF or CE and approval by Trust Board	Waiver not permissable
Selection requirements		Best value obtained	Minimum 3 written quotes requested and 3 returned	Minimum 3 written quotes requested and 3 returned	Minimum 6 tenders requested and 4 returned	Compliant with OJEU procedures
Receipt of offers		Offers to budgetholder or nominated deputy	Offers return to Capital Team/Estates HC/HE manages offer receipt and opening procedures	Offers return to CE office Secretary to Trust Board manages receipt and opening procedures		
Acceptance		Budgetholder or nominated deputy	Lowest - or approval by HC/HE or DE and reported Audit Committee	Lowest - or approval by DF or CE and reported Audit Committee	Recommended by DF or CE and approval by Trust Board (subject to approvals in line with delegated limits for capital investment)	
Signing purchase agreements		Capital Team Project Manager	Signed by HC/HE or DE	Signed by DF or CE	Signed by DF and CE	
Records		Budgetholder must be able to justify actions taken and demonstrate best value	Quotations register maintained by HC/HE	Tenders register maintained by Secretary to Trust Board		
			Retention of documents managed by HC/HE			

Key:	CE = Chief Executive	DF = Director of Finance	DE = Director of Strategic Estates	D = Director	HC = Head of Capital HE = Head of Estates

AUTHORISATION LIMITS - FOR ALL SUPPLIER TRANSACTIONS (SUPPLIES, SERVICES, CONSTRUCTION AND WORKS)

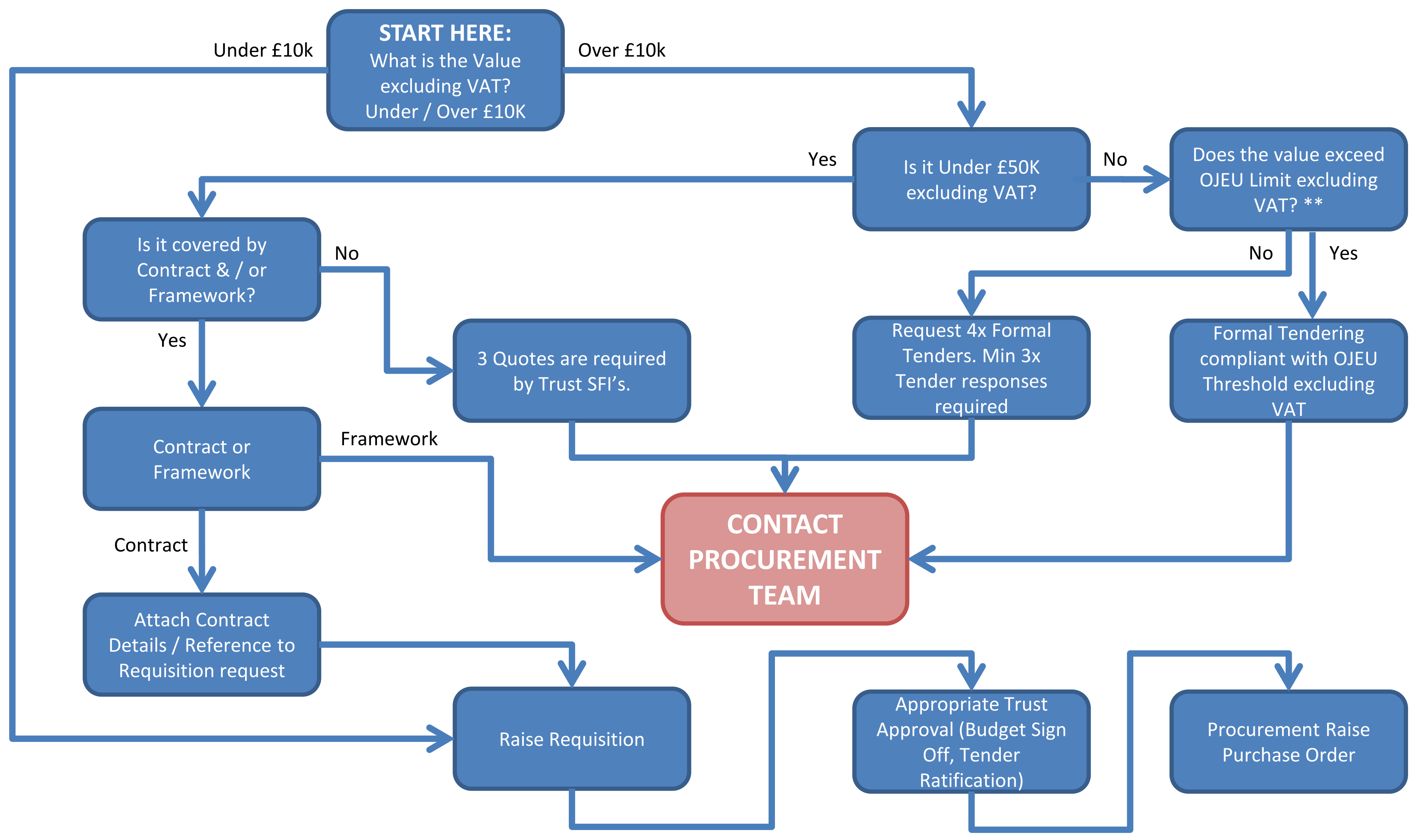
Authorisation of:		Financial limits – For individual transaction values of:			
		< £5,000	**< £50,000**	**< £106,047 OJEU limit)**	**Any value**
REQUISITIONS	Construction and works	BH or ND or (1)	DGM	GM	D
	Supplies and services	Note: certain transactions subject to additional approvals by: IT; EBME; Bioengineering; Finance (charitable/capital funds)			
		BH or ND or (1)	DGM	GM	D
	Supplies from NHS Supply Chain	BH or ND or (1)	DGM	GM	*n/a*
	Call off against existing orders	BH or ND or (1)	DGM	GM	*n/a*
PURCHASE ORDERS	via Supplies	(1)	BTM	SCM	HOP or DF
	via Pharmacy	For medicines transactions only			
		(2)	(2)	HP	DO or DF
	via Catering	For catering consumables transactions only			
		(4)	(4)	CM	DE or DF
	via Estates	For construction and works transactions only			
		(5)	(5)	HE	DE or DF
GOODS RECEIPT	via Supplies	(1)			
	via Pharmacy	(2)			
	via Pathology	(3)			
	via Catering	(4)			
	via Estates	(5)			
INVOICES	Against capital schemes	Authorised by budget holder			
	Matched invoices	Electronic matching where invoice matches purchase order and goods received notification (HSMC and Accounts Payable resolution of mismatches)			
	Unmatched invoices	BH	DGM	GM	CE, DF, D

Key

- CE = Chief Executive
- DF = Director of Finance
- DDF= Deputy Finance Director
- FC = Financial Controller
- DE = Director of Strategic Estates
- DO = Director of Operations
- D = Director
- HOP = Head of Procurement
- GM = General Manager/Divisional Director/ Associate Director
- DGM = Deputy General Manager or equivalent e.g. Matron/Finance Manager
- BH = Budget Holder
- ND = Nominated Deputy
- SCM = HSMC Supply Chain Manager
- BTM = HSMC Buying Team Manager
- HP = Head of Pharmacy
- CM = Catering Manager
- HE = Head of Estates
- (1) = Staff member nominated by DGM
- (2) = Staff member nominated by HP
- (3) = Staff member nominated by HP
- (4) = Staff member nominated by CM
- (5) = Staff member nominated by HE

In addition to the limits shown in the table above, it is permissible for the Deputy Director of Finance or the Financial Controller to electronically approve invoices in excess of the OJEU limit in the following circumstances (i) where there is a formal Service Level Agreement in place and the invoice has been checked, approved and coded by the appropriate budget holder (ii) for Pharmacy invoices where they have been checked, coded and approved by the Head of Pharmacy (iii) for consolidated NHS Supply Chain invoices (iv) utility invoices where they have been checked, approved and coded by the budget holder (v) invoices relating to capital expenditure where project manager has checked them against contract schedules or completion statements. In the absence of the Director of Finance, the Deputy Director of Finance may act as a substitute in respect of the requisition of supplies and services and the approval of invoices.

ENHT Goods and Services Procurement



See intranet pages for Procurement Team contact details or visit www.hertsprocurement.nhs.uk

** See OJEU web page: http://www.ojeu.com/thresholds.aspx

NB: To open links Right Click on the link and select "Open Hyperlink"

Our vision: "To be amongst the best"

Agenda Item:13

TRUST BOARD MEETING – 28 SEPTEMBER 2016

CHARITY TRUST COMMITTEE – 12 SEPTEMBER 2016
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Trust Board the report from the Charity Trust Committee meeting of 12 September 2016
PREVIOUSLY CONSIDERED BY	N/A
Objective(s) to which issue relates *	[x] 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. [x] 2. **Developing new services and ways of working** – delivered through working with our partner organisations [ ] **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key assurance committee reporting to the Board Financial risks as outlined in paper
Healthcare/National Policy (includes CQC/Monitor)	Potential risk to CQC outcomes Key statutory requirement under SFIs, SOs. Healthcare regulation, DH Operating Framework and other national performance standards
CRR/Board Assurance Framework *	[ ] **Corporate Risk Register** [✓] **BAF**
ACTION REQUIRED *	For approval [ ] For decision [ ] For discussion [✓] For information [ ]
DIRECTOR:	Chairman of CTC
PRESENTED BY:	Chairman of CTC
AUTHOR:	Corporate Governance Officer/Company Secretary
DATE:	September 2016

We put our patients first We work as a team We value everybody We are open and honest We strive for excellence and continuous improvement

CHARITY TRUSTEE COMMITTEE MEETING HELD 12 SEPTEMBER 2016

SUMMARY REPORT TO BOARD – 28 SEPTEMBER

The following members were present: Mr Niven (Chair) and Mr Posey

Key Decisions made under delegated authority:

The Charity Trustee Committee (CTC) made the following decisions on behalf of the Trust under the authority delegated to it within its terms of reference:

The CTC approved the following bids for funding:

Macmillan Education Project (£120,242): The CTC considered a proposal for expenditure of existing funds for a year's funding for 2 posts (band 7 and 8a) to work towards a vision of a Mount Vernon school of oncology training and education. The total length of the project was two years. Macmillan had committed to providing costs to support the first 12 months of the project, but required assurance that matched funding would be available to support Year 2. Part of the remit of the posts would be to investigate a means of making the posts sustainable through alternative funding streams. The CTC supported the proposal, subject to clarification of employment of the posts with HR. The Committee requested that a report providing an update on the project be submitted after one year.

Butterfly Project (£22,758): The CTC was asked to consider whether charity resources could be expended in raising new funds for a Butterfly Volunteer Coordinator post. The Committee expressed support for the Butterfly Volunteer Project, which aimed to provide one to one compassionate listening, comfort and companionship for patients who had been identified as being in the last few days and hours of life, particularly for those with few or no visitors who would otherwise be alone. It was noted that it was envisaged that the Trust Charity would be approached for further funding in future to raise funds for the recurrent costs, possibly in partnership with local hospices. It was explained that there was not currently a fund available for the project. If approved by the Committee, the Charity team would look to raise the money requested but the funding could not be guaranteed. The CTC approved the proposal, subject to funding being found and that that part of the remit of the role be to investigate alternative funding streams for the recurrent costs. It was also noted that as the funds would have to be raised prior to implementation they might not be available as early as had been hoped.

Other outcomes:

Matters Referred from the Board

The CTC had been asked by the Trust Board to review their draft strategy and to look into expenditure against raised funds by the Charity. This was considered by the Committee at the meeting and further details can be found below. The Board had also asked the CTC to consider the ethics of running a lottery. This was discussed during the meeting and it was decided that the CTC were comfortable with the ethical position, however would review whether it remained worthwhile financially.

Women and Children's Fund Management Report

The CTC received a summary of the current charitable funds managed by the Women and Children's Division. The Division currently held 10 funds with a total balance of just over £81k. The largest two funds were FANS – SCBU and Magic of Play. It was noted that the original aim of the Magic of Play fund had been completed and that it was important to ensure that the objectives of the fund were updated accordingly. The Division were not

currently actively fund raising but were aware of interest in children's services from fundraisers and were working closely with the Charity to move this forward.

Clinical Support Services Fund Management Report
The CTC received a summary of the current charitable funds managed by the Clinical Support Services Division. The Division held 11 small funds with a total balance of £15k. In the past year funds had been consolidated from 17 funds and work was underway to consolidate the remaining funds further. The Division acknowledged that whilst they generally received fewer donations than other services due to the placement of the services they provided in patients' pathways, they could play a role in promoting and raising the profile of the Charity. This included promoting the Trust's free patient Wi-Fi (funded by the Charity) and working to add the Charity's logo to all of the appointment letters sent from the contact centre. The CTC welcomed these actions.

Charity Management Team Update
The CTC received an update from the Charity Management Team. The Charity currently had a full complement of staff and changes had taken place regarding the staff structure so that the Head of Charity was now line manager for each fundraiser. The report included updates regarding legacies and charitable appeals.

Draft Charity Strategy and Strategy Progress report
The Committee approved the draft Charity Strategy 2016/17 for submission to Trust Board in September. In relation to progress against the strategy, all KPIs were green for Quarter 1 with the exception of the pence in the pound target, for which work was underway.
See separate agenda item for further information.

Expenditure on Raising Funds 2016/17
The Committee discussed progress towards reducing overhead costs so that they did not exceed 25 pence per pound. The Committee were informed that a benchmarking exercise undertaken by the Association of NHS Hospital Charities, which had reviewed the finances of 83 NHS hospital charities, had found that the average expenditure against raising funds was 30%. It was noted that charities' incomes varied significantly depending on their size and profile and this in turn affected any given charity's ability to influence expenditure against raising funds. It was agreed that a further benchmarking exercise would be undertaken to attempt to compare the Trust against other trusts of a similar size. It was concluded that achieving expenditure against raising funds of 25p per pound might not be achievable in the current year, but the CTC remained committed to reducing this to a minimum.

Income Activity Report
The CTC reviewed the income activity since the close of Quarter 1 accounts for the months of July and August 2016 and detail of income forecast in September and onwards. Closing income for the year to date was £273k, which equated to a negative variance of £36k in the year to date. An additional £49k would be needed on top of the original target for September in order to reach the Q2 target. Details of income activity since Q1 were also provided, with a number of activities underway and planned.

Charity Finance Report
The CTC reviewed income and expenditure for the period to 30 June 2016. Overall there was a favourable variance of £10,765 to plan. The Committee discussed cash flow and requested a detailed forward view at the next meeting. It was noted that since last CTC meeting the investment portfolio had been transferred to Rathbones.

Investment Portfolio Update
The CTC noted the closing report of the Trust's outgoing investment advisers, Investec Wealth Management, as at June 2016. Representatives from the Trust's new investment advisors (Rathbones) attended the meeting and provided an update on the Trust's portfolio since the transfer of ownership. The Committee were encouraged by the initial positive growth in investments.

CTC Annual Review 2015/16 and Review of Terms of Reference
The Committee considered the annual review of the CTC. The review concluded that the Committee had fulfilled its functions as set out within its Terms of Reference. It was noted that the Terms of Reference had been updated to include the Director of Nursing as a core member of the Committee. The review was approved for submission to Trust Board (attached at Appendix 1).

Charity Annual Report / Accounts 2015/16
The CTC noted the Annual Report and Accounts, approved in May 2016.

Bob Niven
Chair September 2016

Charity Trustee Committee
Annual Review 2015/16

EXECUTIVE SUMMARY

As set out in the terms of reference the Charity Trustee Committee (CTC) is a committee of the Board in its role of Corporate Trustee and with responsibility:

- to ensure a robust strategy for the delivery of The Charity aims and objectives;
- to champion The Charity and its development, providing leadership both within the Trust and externally;
- to provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies.

This is a delegated duty carried out on behalf of the East and North Hertfordshire NHS Trust, which is the sole *Corporate Trustee* of East & North Herts Hospitals Charity (registered charity no. 1053338).

This is the annual review of the CTC which considers how the Committee has met its duties under its terms of reference. A review of the minutes and reports to Board, and a review of the Trust's Standing Orders and Financial Instructions have been used to inform this report. Where areas for improvement were identified, the agreed actions were noted or recommendations made. Due to changes to the Chair and other committee membership as highlighted below in 'Summary of Findings', an annual survey/self-assessment review of the efficiency of the CTC has not been undertaken; this will be implemented for the 2016/17 annual review.

The overall conclusion of this annual review is that the Committee has discharged its duties under its terms of reference during 2015/16. The CTC continues to champion and raise awareness of The Charity and its development, both externally and within the Trust, provides stewardship of charitable resources and ensures compliance with relevant legislation, guidance and Trust policies. The Committee and team are committed to continue to strengthen the charity and governance arrangements during 2016/17.

The Board as Corporate Trustee is asked to note the report and approve the revised terms of reference (appendix 1 attached); there are no material changes other than attendance by a nursing representative to represent a clinical viewpoint and the trust Financial Controller to continue to strengthen the financial governance.

SUMMARY OF KEY FINDINGS

Meetings and Membership

The CTC met four times during 2015/16 and all meetings were quorate under current terms of reference. In May 2015 the Chair of the Committee and leadership of the Charity was revised. From September 2015 the Charity reported to the Head of Engagement and sat within the portfolio of the Director of Strategic Development. The Head of Hospital Charities was replaced by an Interim Head of Hospital Charities who remained in post until May 2016. An Interim Charitable Funds Accountant was appointed towards the end of July 2015. Membership attendance was recorded in the Trust Annual Report; no issues were identified. The minutes demonstrated where scrutiny and appropriate challenge had been presented during meetings.

Strategic

Charity Governance
The CTC ensured policies and procedures were in place to allow the effective day-to-day management of The Charity and its funds. In September 2015 the CTC supported a review of the Charity and its structure undertaken by the Interim Head of Hospital Charities. The

Committee approved proposed actions to increase income, monitor expenditure, improve the fundraising database and develop the Charity's marketing on and off-line. The CTC agreed that expenditure would be patient focussed and supported that divisions identified projects for charity funding at the beginning of the year commencing January 2016 to ensure more divisional support at Charity Management Team meetings.

The CTC was committed to reducing the ratio of costs required to generate income and apportionment percentage charges for management recommending the target be set at 25p in the pound. In March 2016 the ratio was 26 pence in the pound against 33p plan 2015/16 owing to a reduction in costs and legacy income.

Throughout 2015/16 the Committee continued to develop the charity risk register and reviewed and approved Key Performance Indicators (KPI's) which were updated to reflect objectives and requirements for the year.

The CTC monitored progress of the Charity structure review and in December 2015 supported recommendations made to:

- recruit a new Head of Charity and Lister fundraiser setting clear financial targets, objectives and line management direction for MVCC fundraisers;
- support a draft funding checklist providing clarity to fund holders on process/decision-making for charitable funding expenditure;
- notify staff that charitable funding of Christmas parties would cease from 2016, promoting that staff nominate items of expenditure which would benefit all staff;
- implement rigorous monitoring of key performance indicator targets.

In March 2016 the CTC received an outline and breakdown of the Charity's income and expenditure budgets for 2016/17 and approved the targets set.

Also in March 2016 the Charity considered a draft Charity Strategy for 2016/17 and supported the recommendations made to:

- increase return on investment;
- control expenditure in line with donors' wishes;
- ensure fund managers followed processes to maximise income and expenditure.

The framework strategy 2016/17 was submitted to Board in March where it was approved in principle with a request that further work be undertaken to ensure the ratio of administrative costs to income was 25 pence in the pound by the end of 2016/17.

Charitable Management Team (CMT) Meetings

The CTC received regular updates on activities of the Charity Management Team (CMT) meetings. In May 2015 the CTC recommended simplification of the approval process for applications over £5k. To support charity efficiency and ensure fund managers reached expenditure objectives, the CTC requested sight of phased expenditure. In September 2015 the Committee supported actions undertaken to improve attendance at CMT meetings and received updates on progress. Following a report in December 2015 that CMT meetings had improved to include clinical representation, the CTC was disappointed to note in March 2016 attendance at CMT meetings had declined. The CTC supported a revision of the membership and introduction of quarterly workshops for fund managers, to provide proactive advice and support on fundraising income and expenditure. The CTC received assurance that all charity staff and volunteers undertook DBS checks on recruitment.

Divisional Fund Management Reports

Throughout 2015/16 the CTC received divisional fund management updates on charitable activities to provide the Committee with information on what divisions were delivering well in terms of use of charitable funding and what was proving more challenging with reasons and next steps. The Charity supported consolidation of small funds and those not utilised within 12

months. The main focus of the MVCC fundraisers was the Lynda Jackson Macmillan Centre (LJMC) "Here if you need us" campaign.

Annual Report and Accounts 2014/15 and 2015/16
In May 2015 the CTC considered and endorsed The Charity Annual Report and Accounts 2014/15 recommending submission to Audit Committee on 18 May 2015, followed by final approval and sign-off at Board on 27 May 2015, in line with the Trust's Annual Report and Accounts 2014/15. External Audit findings against significant risks provided assurance no significant issues or errors within the financial statements and issued a 'limited assurance' opinion.

In March 2016 the CTC approved the Charity's draft annual report 2015/16. The Charity's Annual Report and Accounts were submitted to Audit Committee for approval on 23 May 2016, in line with the Trust's main Annual Report and Accounts, followed by final approval and sign-off at Board on 25 May 2016. External Audit independent examination findings confirmed no significant issues or errors had been identified and limited assurance opinion would be issued.

Investment Policy and Portfolio
The CTC received regular updates from the Trust's investment adviser on the Charity's portfolio. Performance to the end of quarter 1 in June 2015 was down on the previous year and against the market as a whole. For this reason, in December 2015, the CTC supported an investment contract retendering process which began in January 2016. In March 2016 the CTC approved that from 1 May 2016 management of the Charity's investment portfolio be transferred from Investec Wealth and Investment to Rathbone Investment Management. The CTC noted Investec had been in post for ten years and recommended the re-tendering process be undertaken every three years in order to achieve the best return and support package.

Operational

Charity development
The minutes and papers demonstrate a range of fundraising activities for campaigns such as the Forget-Me-Not Appeal, a fund raising campaign to improve the Trust's care for patients with dementia, and the 'Here if you need us' campaign at Mount Vernon. In May 2015 the CTC agreed to continue the fundraising campaign 'Magic of Play', which funded a new playroom on the children's ward, since its clear recognisable brand continued to attract fundraising and the Charity was keen to continue momentum and support further development in children's services.

In December 2015 the Committee approved a fast-track process for consideration of funding proposals from the Patient Experience Committee to cover provision of slippers and other similar items to improve the patient experience.

Income activity
The CTC received regular updates on top line income activity and progress of the Charity to meet income plan 2015/16. Challenges during the year related to lower than expected legacy income, delays in recruitment and variances to planned income/expenditure. To promote visible activity across the Trust the CTC approved an undertaking to review the appeal since the Forget-me-not Appeal was behind trajectory.

Activities during 2015/16 included:

- a Dementia Awareness Day on 21 May 2015;
- a House of Lords Dinner on 29 September 2015;
- a secret art sale;
- Golf days at Chesfield Downs in July and another on 23 September;
- It's a Knockout on 12 September;
- Moor Park 10k and junior fun runs on 27 September;
- a firewalk event in November.

In December 2015 the Charity supported a proposal relating to Mount Vernon Comforts Fund Trustees, its volunteers and E&NHT Charity and ways of working collaboratively to further improve the patient experience.

Throughout 2015/16 the CTC continued to raise the charity's profile throughout the local community via retail outlets, local media and major corporations. This included attendance at the Trust's Annual General Meeting as well as a presence at the annual staff ceremony for Excellence Awards.

Approvals of Expenditure
During 2015/16 the CTC reviewed and endorsed funding requests for the following from charitable funds:

- £43,081 for state-of-the-art breast boards;
- £28,214 to extend the Community Engagement Team at Mount Vernon Cancer Centre to September 2016;
- £20,000 (subject to confirmation of costs) to enhance the patients and staff environment at Nuclear Medicine, Mount Vernon;
- £7,500 from a staff wellbeing fund to sponsor a staff seasonal celebration at Mount Vernon;
- £88,700 (subject to cost control implementation) to fund a Trust-wide patient/public Wi-fi service;
- £110,000 for building and equipment costs to develop a Renal Interventional Treatment Area;
- funding for the Race Director of the 2016 Moor Park 10k race.

Decisions made under delegated authority

During 2015/16 the CTC made the following decisions on behalf of the Trust under the authority delegated to it within its terms of reference:

- The CTC agreed the use of funds from account 1212 (money from earned income through research trials) to support research staff salaries;

- The CTC approved a third party cheque indemnity to enable the Charity to bank cheques made out in the name of individual funds or charity appeals;

The CTC also approved the following policies:

- Management of Celebrities, VIP's and other high profile supporters of the Trust's charity;

- Promoting other charities on the Trust's estate.

Reporting to Board

The Committee has reported to the Trust Board as Corporate Trustee following each meeting and the CTC actions logs provide a clear audit trail of actions agreed through to closure.

CONCLUSION

The overall conclusion of this annual review is that the Committee has discharged its duties under its terms of reference during 2015/16. The CTC continues to champion and raise awareness of The Charity and its development, both externally and within the Trust, provides stewardship of charitable resources and ensures compliance with relevant legislation, guidance and Trust policies.

The Committee and team are committed to continue to strengthen the charity and governance arrangements during 2016/17.

The Board as Corporate Trustee is asked to note the report and approve the revised terms of reference (appendix 1 attached); there are no material changes other than attendance by a nursing representative to represent a clinical viewpoint.

Appendix 1

CHARITY TRUSTEE COMMITTEE
TERMS OF REFERENCE

1. Purpose & Authority

The purpose of the Charity Trustee Committee is:

- To ensure a robust strategy for the delivery of the Charity aims and objectives.
- To champion the charity and its development, providing leadership both within the Trust and externally
- To provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies

This is a delegated duty carried out on behalf of the East and North Hertfordshire NHS Trust, which is the sole *Corporate Trustee* of the Charity, East and North Herts Hospitals Charity (registered charity no 1053338).

2. Authority

The Charitable Funds Committee is authorised:

- to investigate any activity within its Terms of Reference.
- to obtain reasonable external legal or other independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

3. Membership of the Committee

Membership (with voting rights):

- two Non-Executive Directors
- Director of Finance
- Director of Strategic Development
- Director of Nursing

In attendance:

- Head of Charities
- Charity Financial Accountant
- Company Secretary
- Head of Engagement
- Trust Financial Controller
- additional attendees selected by the Committee as deemed necessary to fulfil its function, including the Charity Independent Investment Advisor at least annually, and Director of Business Development and Partnerships.

The Chair of the Committee shall be one of the Non-Executive Directors selected by the Board. In their absence, meetings shall be chaired by the other Non-Executive Director.

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

4. Quorum

A minimum of two members must be present, of which one must be a Non-Executive Director and one must be an Executive Director.

5. Meetings

The Charitable Trustee Committee will meet at least four times a year (as near as practical to quarter ends). The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

6. Key duties and responsibilities

a. To ensure a robust strategy for the delivery of The Charity aims and objectives including:

- To approve and monitor The Charity and Strategy and Charity Management Team Annual Plan and Priorities.

b. To provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies

- Ensuring policies and procedures are in place that allow the effective day to day management of the charity and its funds
- Ensuring The Charity satisfies all regulatory, legal and NHS compliance requirements
- Ensuring funding provides added value to patients and staff, above those afforded by Exchequer Funds
- Ensuring expenditure is in line with donors' expectations of an NHS Charity
- Ensuring effective systems are in place to manage budget holders and ensuring they demonstrate adherence to charitable objectives in spending charitable monies
- To recommend the appointment of Investment Managers to provide investment advice and manage the Trusts investment portfolio through an agreed Investment Policy, so as to safeguard the charity's future while maximising income.
- Ensuring The Charity's financial dealings are systematically accounted for
- To ensure appropriate mechanisms are in place to manage restricted and designated monies, and to use monies as agreed with the donor or negotiate alternative arrangements
- Receive and provide scrutiny to The Charity's Annual Report and Accounts, prior to final approval by the Corporate Trustee,
- Encouraging a culture of expending expendable income unless there is a clear reason to accumulate
- Establishing a Reserves Policy and monitoring its implementation
- Providing assurance updates to the Audit Committee regarding the governance and risk management of the charitable funds
- Reviewing and approving the Fundraising and Communications Strategies and the resources required to implement them
- Monitoring performance against financial and other key performance targets
- Setting a clear framework for prioritising charitable expenditure, and establishing appropriate approval processes for agreeing new campaigns and spending existing charitable monies
- To ensure appropriate delegation of charitable expenditure
- To authorise the establishment of any new funds
- For charitable funds' schemes with a value of £5,000 and over:
    - Reviewing and, if appropriate, authorising
    - Ensuring that the Investment Committee, and where appropriate the Executive Committee, reviews and monitors the application and implementation of charitable funds schemes.

c. To champion The Charity and its development, both externally and within the Trust to include:

- Providing inspiring, reflective and visible leadership of the charity, clearly communicated to all stakeholders
- Growing the reputation and profile of the Charity (and by association, the Trust)
- Advocating and being ambassadors for charitable giving to the Charity within the community
- Developing through high donor activities a network of seriously influential stakeholders who see themselves as business partners in the Trust's future, and personally cultivating and stewarding these relationships
- Leading and encouraging the Board in achieving similar and appropriate support for the Charity.

7. Reporting arrangements

The Committee will report to the Trust Board, as Corporate Trustee, following each meeting.

8. Support

The Company Secretary will advise the Committee on pertinent governance issues and ensure it is supported administratively, including:

- Agreement of agenda with Chairman and attendees and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward

9. Review

The Terms of Reference of the Committee shall be reviewed by the Trust Board (Corporate Trustee) annually.

Agenda item: 13.1

TRUST BOARD COMMITTEE (PART I) – 28 SEPTEMBER 2016

CHARITY STRATEGY PROGRESS REPORT

PURPOSE	To present to the Trust Board the new public-facing Charity Strategy 2016-17 and a brief update on progress against the Strategy.
PREVIOUSLY CONSIDERED BY	**CTC –September 2016**
Objective(s) to which issue relates *	[x] 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. [x] 2. **Developing new services and ways of working** – delivered through working with our partner organisations [x] **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	To ensure the Charity Strategy is being implemented
Healthcare/ National Policy (includes CQC/Monitor)	Non Identified
CRR/Board Assurance Framework *	[x] **Corporate Risk Register** [ ] **BAF**
ACTION REQUIRED *	For approval [x] For decision [ ] For discussion [ ] For information [ ]
DIRECTOR:	Director of Strategic Development
PRESENTED BY:	Head of Charity
AUTHOR:	Head of Charity
DATE:	13 September 2016

We put our patients first We work as a team We value everybody We are open and honest
We strive for excellence and continuous improvement

Charity Strategy Progress Report

1. Executive Summary

In March 2016 the Board, as Charity Trustee, considered the Charity Strategy 2016/17 and requested a further review once the new Head of Charites was in post, and in particular to reflect the aim to reduce the pence per pound spent on overheads to be added to the strategy and to consider whether to continue with the lottery (for ethical and commercial reasons). This paper presents to the Board, the new public-facing Charity Strategy 2016-17 for approval and provides feedback on the two areas raised and a brief update on progress against the Charity Strategy 2016-17.

The Board, as Charity Trustee is asked to note the report and approve the public facing strategy.

2. Charity Strategy 2016/17

The Charity Strategy 2016/17 was agreed by the Charity Trustee Committee (CTC) in March 2016 and by Trust Board (as Charity Trustee) subject to reflecting the aim to reduce the pence per pound spent on overheads. The new Head of Charity has reviewed the strategy accordingly and this is now reflected in a public-facing version of this strategy, agreed by the CTC in September 2016 and it submitted to Board for final approval. See appendix 1.

3. Expenditure on raising funds

As outlined in the strategy the Charity is committed to reducing expenditure on raising funds to a minimum and has an ambitious target of reducing this to 25p in the £1. Since April 2016, expenditure on raising funds is 33p in the £1.

Research with 83 hospital charities undertaken in 2015 by the Association of NHS Charities indicates the average expenditure on raising funds is 30p in the £1 and a benchmarking exercise with comparator trusts is currently underway. The CTC is closely monitoring the expenditure on raising funds with a view to further reducing the expenditure by December 2016.

4. Hospital Charity Lottery

The CTC discussed the ethics in relation to operating a hospital charity lottery for Trust staff and concluded it was comfortable with the ethical position and is committed to regularly monitoring any risks associated with this fundraising activity.

5. Charity Strategy 2016/17 – progress

- **Income and expenditure**
  The closing balance for quarter 1 is £19k in surplus against forecast (£169k income, £254k expenditure)

Performance is on track to meet the quarter 2 target and it is forecast that annual income of £1.2m and expenditure of £1.2m will be realised by end March 2017.

- **Expenditure on charitable activity**

  The Charity is pleased to have agreed all requests for charitable funding applications since April 2016. These include enhancements such as a virtual radiotherapy treatment machine, enhanced brachytherapy research and a jointly-funded Macmillan Education Project for oncology training.

  The charitably funded Renal Intervention and Treatment Area (RITA) is due to complete on 4th October 2016.

  The Free Hospital Wi-Fi project has launched across the Lister Hospital and Mount Vernon Cancer Centre and is operating effectively.

- **Charity staff**

  A new permanent Head of Charity started in post in April 2016.
  A new permanent Charity/ENH Pharma Finance Manager started in post in September 2016.
  The four charity fundraisers now report directly to the Head of Charity as their line manager.

Strategic Plan

2016/17

Contents

1 Executive summary

2 Introduction

3 Vision and values

4 Charitable giving

5 Fundraising

5.1 Fundraising Methods

5.2 Donor relations

6 Charity governance

6.1 Key performance indicators

6.2 Fund management

6.3 Charity management information

6.4 Monitoring and review

7 Giving your support

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Executive Summary

Vision and values

This document presents East and North Herts Hospitals Charity's strategy for 2016-17.
Our charitable purpose is to enhance support for East and North Herts NHS Trust staff and patients by raising much needed additional funds for equipment, services and research which the NHS cannot provide. We will always be guided by the Trust's values when carrying out our goals and objectives.

Charitable giving

Our strategic priorities are to support services across the Trust's four sites;

- Lister Hospital, Stevenage
- New QE11, Welwyn Garden City
- Hertford County Hospital, Hertford
- Mount Vernon Cancer Centre, Northwood, Middlesex

Our strategy focuses on major appeals across these sites, including;

- The Forget Me Not Appeal (aiding dementia-friendly services)
- The Magic of Play Appeal (aiding recovery of children and young people)
- The Mount Vernon Cancer Centre Charitable Fund (aiding specialist cancer care facilities)
- The Lynda Jackson Macmillan Centre (aiding provision of information, support and holistic therapy services at Mount Vernon Cancer Centre).

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Executive Summary

Fundraising

We have set ourselves an ambitious yet realistic annual charitable fundraising target of £1.2 million. This will be achieved through the following fundraising methods:

- Donations; from individuals, in memoriam and major donors
- Events and community fundraising
- Corporate giving/sponsorship
- Legacies and bequests
- Trusts and foundations

We will continue to improve our relations with our donors to whom we are indebted, ensuring we express our gratitude for their generosity, thank them accordingly and keep them involved at all stages of their giving journey. We will also work hard to maintain and strengthen existing and newly formed relationships so that our donors know they are valued.

Charity governance

We will continue to improve our charity governance, ensuring we keep our charitable overheads to the very minimum, thereby maximising the impact of our charitable giving. We will exercise effective management of our internal funds, ensure our donors' wishes are honoured, improve our communications, information governance systems and reporting and accurately review and report on income and expenditure throughout the year.

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Introduction

I am delighted to present East and North Herts Hospitals Charity's strategy for 2016-17.

We start the year in a period of transition; from a position of satisfactory performance, raising £939k in 2015-16 and spending £1.3m; just over our planned expenditure. This has enabled the Charity to enhance support for East and North Herts NHS Trust patients, families, staff and visitors in numerous ways, including our cancer information and support services, purchasing much needed items of equipment, funding research, purchasing play facilities for our children and young people and providing services such free hospital patient Wi-Fi provision, all of which enhance the experience of our patients and carers.

It is an exciting year ahead for the Charity. I am delighted to welcome a new Head of Charity for the organisation who will manage the daily charitable operations and who is supported by a dedicated fundraising team and financial staff. With the collective experience of our charity team, I am confident the charity will deliver the strategic objectives set out below and make a demonstrable difference in enhancing the experience of East and North Herts NHS Trust patients, families, staff and visitors.

This strategy sets out our ambitions for 2016-17. The Charity Trustee Committee has set a fundraising target of £1.2 million and a budgeted expenditure of £1.2 million. Our plan sets out the ways in which the charity will raise these much needed funds, with the invaluable support of Trust staff, patients, businesses and members of the community. I hope you will join us in delivering our plan for 2016-17 and sincerely thank you for taking an interest in and for supporting the charity over the coming year, through your fundraising, your donations and by spreading the word of our charitable activities.

Very best wishes,

Bob Niven

Chair, Charity Trustees Committee

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Vision and values

Our charitable purpose is to enhance support for East and North Herts NHS Trust patients, families, and loved ones, staff and visitors. Through fundraising and donations we provide equipment, services and research which complement and enhance those provided through NHS funding.
In delivering our charitable purpose, we will be guided by the values developed by East and North Herts Trust, in delivering our activities, as set out below;

Our values

Our vision is 'To be amongst the best' and our Trust values are PIVOTAL in helping us to achieve this aim. We expect all our staff across the Trust to demonstrate, promote and encourage these values.

Our values are

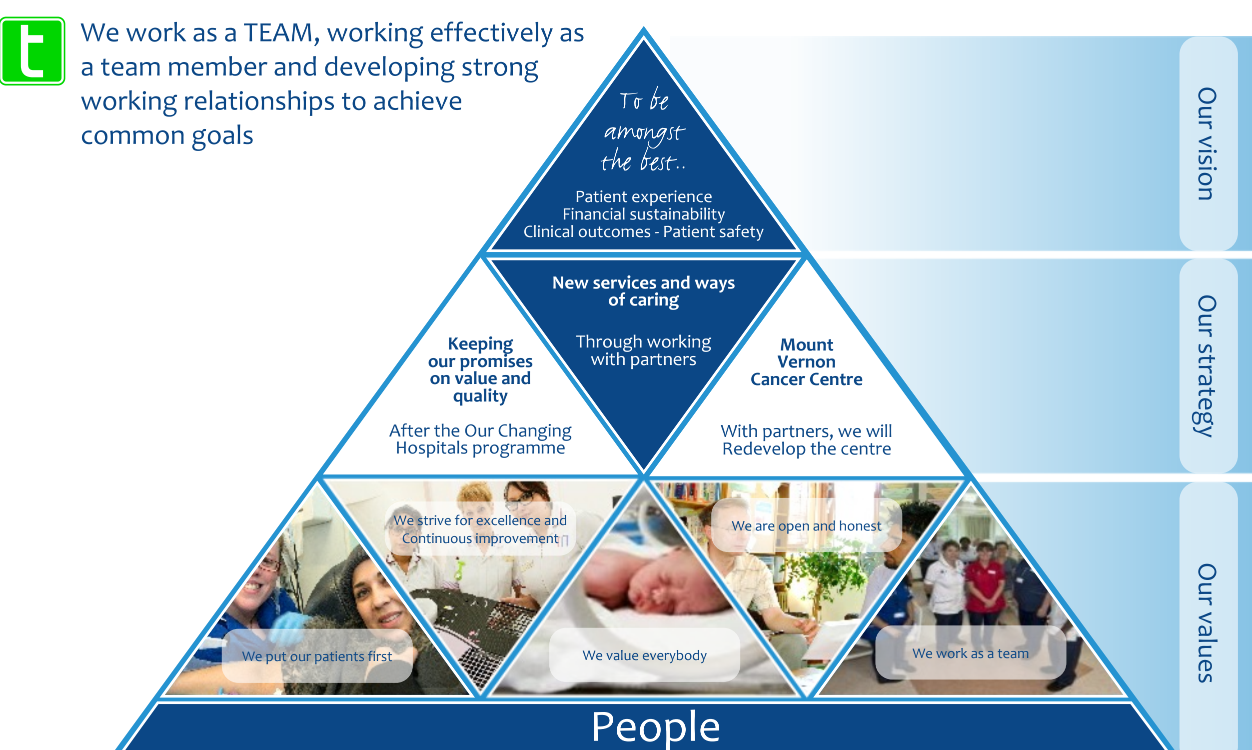
p We put our PATIENTS first, focusing on the patient to provide high quality care and a service that is tailored to the individual.

i We strive for excellence and continuous IMPROVEMENT, taking personal responsibility for making things happen and achieving results.

v We VALUE everybody, considering and showing respect for the opinions, circumstances and feelings of colleagues and members of the public.

o We are OPEN and honest, ensuring that we communicate with tact, diplomacy and transparency, that information is accurate and that others feel able to ask questions

t We work as a TEAM, working effectively as a team member and developing strong working relationships to achieve common goals



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Charitable giving

All our charitable spending is carefully considered to ensure we are enhancing our local NHS Trust provision and not replacing NHS care.

Our strategic priorities are to support services across the Trust's four major sites;

- Lister Hospital, Stevenage, Hertfordshire
- New QE11, Welwyn Garden City, Hertfordshire
- Hertford County Hospital, Hertford, Hertfordshire
- Mount Vernon Cancer Centre, Northwood, Middlesex

Our strategy focuses on the following major appeals across these sites;

- The Forget Me Not Appeal (aiding dementia-friendly services)
- The Magic of Play Appeal (aiding recovery of children and young people)
- The Mount Vernon Cancer Centre Charitable Fund (aiding specialist cancer care facilities)
- The Lynda Jackson Macmillan Centre (aiding provision of information, support and holistic therapy services at Mount Vernon Cancer Centre).

We will give consideration to additional large-scale appeals in 2016/17, depending on availability of resource and in doing so will seek appeals that hold wide-ranging benefit for as many of our patients, families, staff and visitors as possible.

In addition to our general appeals we are committed to funding specific projects in 2016/17, such as the free hospital Wi-Fi project, supporting the work of the Community Engagement Team at Mount Vernon Cancer Centre and funding otherwise unaffordable equipment, research and refurbishments.

We are ideally placed as a charity to harness the generosity, enthusiasm and support of the community in achieving our goals. With 5,000 staff employed across the Trust, a patient catchment area of over 2.6 million and a wide range of health specialties to support, we hope we will capture the imagination of the public and have a successful year of fundraising ahead.

We want to achieve as much as possible in 2016/17 to support our patients, their families, our staff and visitors and hope you will join us on our journey. There is huge scope to make a difference.

Fundraising

5.1 Fundraising methods

We will work with our donors and supporters from across the community to raise awareness of the opportunities for charitable giving through East & North Herts Hospitals Charity.

We are extremely fortunate to work with some of the most generous individuals; patients, families and friends, Trust staff and members of the community who offer their time, expertise and generosity to raise much needed funds to support our charitable giving.

We are also indebted to the kindness, hard work and generous contributions from many local businesses, societies, community groups and clubs who are passionate about supporting their local hospitals and health services and who make a valuable contribution each year.

In 2016/17 we will focus on assisting our supporters to achieve their fundraising goals and to raise funds for the causes and appeals for which they are most passionate. We will also lead a range of charity-led events and opportunities in which our supporters can participate to raise funds for our general appeals.

We will focus our fundraising efforts on the following key areas:

- Community-led giving
- Corporate giving/charity of the year
- Donations; from individuals, in memoriam and major donors
- Events (charity-led and challenge events)
- Legacies and bequests
- Trusts and foundations

Fundraising

5.2 Donor relations

We are indebted to our wonderful donors and supporters, who continue to demonstrate huge kindness, generosity and support in furtherance of our charitable aims.

We are committed to showing our thanks and gratitude to our donors; by ensuring we thank them for their support and by informing, involving and engaging them in our work on a continued and timely basis.

We will, as a charity team, make best use of our customer relation management (CRM) systems to ensure that donors are recognised, thanked and kept informed of the charity's work, whilst ensuring that our supporters only receive the communications they opt to receive.

We will always ensure the personal details of our donors are protected in line with the Data Protection Act and that details will never be shared with external parties.

We will always respect the anonymity of donors where this is their preference.

I am supporting my hospital to make a difference to people's lives

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Charity governance

6.1 Key performance indicators

We have set ourselves the following key performance indicators (KPIs) against which we will measure the success of our performance:

- Secure annual income of £1.2m for 2016/17
- Spend £1.2 million on charitable activities in 2016/17
- Keep charitable overhead expenditure to a minimum
- Improve charity management information

In order to achieve our KPIs our charity structure will need to be fit for purpose. We are committed to ensuring that the Head of Charity is fully accountable to the Charity Trustee Committee and equipped to effectively performance manage through line management of the fundraising staff.

6.2 Fund management

Our charity works in partnership with East & North Hertfordshire NHS Trust (ENHT) colleagues, who take on fund manager signatory responsibilities to co-manage over 140 funds.

Effective fund management will impact upon our achievement of our income and expenditure KPIs and will be fundamental to our charitable performance throughout 2016/17.

The Charity will lead a strategic engagement and consultation exercise with ENHT colleagues early in the year to ensure that the charity's fund managers are supported to:

- Understand their charitable fund management responsibilities
- Effectively implement charitable fund management systems, processes and procedures
- Proactively manage the funds; by increasing charitable activity and actively fundraising
- Rationalise non-active or under-active funds

Charity governance

6.3 Charity Management Information

The ability to develop and sustain a thriving charity depends on the ability to collect, record, analyse and report on a wealth of data through which informed strategic decisions can be made.
The charity will improve its information governance during 2016/17 in the following ways:

- Making best use of our CRM system to collect, record and report financial and donor data
- Increase our charitable profile, communications and visibility with our stakeholders
- Routinely analyse our data to understand our performance and make informed decisions

The ability to routinely understand our performance, particularly against income and expenditure targets, will enable us to deploy our charity team fundraising resources effectively to meet our KPIs.

Charity governance

6.4 Monitoring and review

We will monitor and review performance against our strategy in the following ways:

- Monthly performance reviews at Charity Management Team meetings
- Monthly performance reviews at Charity Team Meetings
- Quarterly performance reviews at Charity Trustee Committee meetings

We will provide performance updates in line with the Charity's Strategy and KPIs to the East & North Herts NHS Trust Board, our corporate trustee, twice a year to provide assurance against our strategic objectives.

We will provide our annual report following March 2017, the end of the charity's financial year, which will provide a summary report of our achievements for 2016/17.

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Giving your support

We are enormously grateful for the generous support of our donors and supporters.
If you would like to get in touch with the charity team, please do not hesitate to contact:

East & North Herts Hospitals Charity
Charity Offices:

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Head of Charity

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East & North Herts Hospitals Charity
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Twitter
@ENHHCharity

Facebook
https://www.facebook.com/enhhcharity/events

Website
http://www.enherts-tr.nhs.uk/get-involved/our-charity/contact-our-charity

DATA PACK

Contents

1. **Data & Exception Reports:**
   FFT
   Health & Safety Indicators
   Nursing Quality Indicators

2. **Performance Data:**
   CQC Outcomes Summary

3. **Workforce Appendices**

4. **Risk and Quality Committee Reports:**

   Safer Staffing
   Infection Control Data

DATA & EXCEPTION REPORTS

FFT
Health and Safety Indicators
Nursing Quality Indicators

Friends and Family Test - August 2016

Inpatients & Day Case	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
5A	100.00	0.00	16	9	0	0	0	0	25	65	38.46
5B	91.67	4.17	16	6	1	0	1	0	24	30	80.00
7B	97.01	0.00	45	20	2	0	0	0	67	182	36.81
8A	96.15	3.85	18	7	0	0	1	0	26	136	19.12
8B	80.56	8.33	19	10	2	0	3	2	36	107	33.64
11B	96.08	0.00	36	13	2	0	0	0	51	99	51.52
Swift	92.94	1.18	60	19	5	0	1	0	85	189	44.97
ITU/HDU	NP	NP	0	0	0	0	0	0	0	5	NP
Day Surgery Centre, Lister	98.52	0.00	161	39	3	0	0	0	203	452	44.91
Day Surgery Treatment Centre	98.39	0.32	260	45	4	0	1	0	310	620	50.00
Endoscopy, Lister	99.02	0.66	272	30	1	2	0	0	305	633	48.18
Endoscopy, QEII	98.91	0.00	83	8	1	0	0	0	92	276	33.33
SURGERY TOTAL	**97.39**	**0.74**	**986**	**206**	**21**	**2**	**7**	**2**	**1224**	**2794**	**43.81**
SSU	94.67	1.33	49	22	3	1	0	0	75	149	50.34
AMU	97.92	0.00	43	4	1	0	0	0	48	124	38.71
Pirton	98.15	0.00	49	4	1	0	0	0	54	63	85.71
Barley	91.30	0.00	14	7	2	0	0	0	23	47	48.94
6A	88.89	7.41	12	12	1	1	1	0	27	64	42.19
6B	95.83	0.00	19	4	1	0	0	0	24	58	41.38
11A	100.00	0.00	85	10	0	0	0	0	95	95	100.00
7AN	97.06	0.00	24	9	0	0	0	1	34	38	89.47
ACU	95.56	2.22	36	7	0	1	0	1	45	156	28.85
10B	76.92	15.38	7	3	1	2	0	0	13	74	17.57
Ashwell	100.00	0.00	20	6	0	0	0	0	26	41	63.41
9B	100.00	0.00	31	4	0	0	0	0	35	39	89.74
9A	100.00	0.00	30	6	0	0	0	0	36	46	78.26
Cardiac Suite	94.74	2.63	65	7	2	0	2	0	76	140	54.29
MEDICINE TOTAL	**96.40**	**1.31**	**484**	**105**	**12**	**5**	**3**	**2**	**611**	**1134**	**53.88**
7A Gynae	80.00	6.25	43	21	11	2	3	0	80	165	48.48
Bluebell ward	100.00	0.00	12	10	0	0	0	0	22	205	10.73
Bluebell day case	50.00	0.00	1	0	1	0	0	0	2	4	50.00
Neonatal Unit	100.00	0.00	18	3	0	0	0	0	21	28	75.00
WOMEN'S/CHILDREN TOTAL	**86.40**	**4.00**	**74**	**34**	**12**	**2**	**3**	**0**	**125**	**402**	**31.09**
Michael Sobell House	100.00	0.00	39	1	0	0	0	0	40	58	68.97
10	100.00	0.00	7	2	0	0	0	0	9	97	9.28
11	100.00	0.00	12	1	0	0	0	0	13	101	12.87
CANCER TOTAL	**100.00**	**0.00**	**58**	**4**	**0**	**0**	**0**	**0**	**62**	**256**	**24.22**
TOTAL TRUST	**96.49**	**1.09**	**1602**	**349**	**45**	**9**	**13**	**4**	**2022**	**4586**	**44.09**

Continued over .....

Inpatients/Day by site	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Lister	96.25	1.18	1461	337	44	9	13	4	1868	4054	46.08
QEII	98.91	0.00	83	8	1	0	0	0	92	276	33.33
Mount Vernon	100.00	0.00	58	4	0	0	0	0	62	256	24.22
TOTAL TRUST	**96.49**	**1.09**	**1602**	**349**	**45**	**9**	**13**	**4**	**2022**	**4586**	**44.09**

Accident & Emergency	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Lister A&E/Assesment	77.02	14.78	850	343	93	90	139	34	1549	8451	18.33
QEII UCC	86.60	7.95	461	127	26	18	36	11	679	4141	16.40
A&E TOTAL	**79.94**	**12.70**	**1311**	**470**	**119**	**108**	**175**	**45**	**2228**	**12592**	**17.69**

Maternity	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Antenatal	96.15	0.00	30	20	1	0	0	1	52	553	9.40
Birth	95.80	0.84	159	69	2	2	0	6	238	455	52.31
Postnatal	91.98	1.27	136	82	9	2	1	7	237	449	52.78
Community Midwifery	83.33	0.00	4	1	1	0	0	0	6	553	1.08
MATERNITY TOTAL	**94.00**	**0.94**	**329**	**172**	**13**	**4**	**1**	**14**	**533**	**2010**	**26.52**

Outpatients	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses
Lister	95.94	1.00	886	271	31	3	9	6	1206
QEII	93.81	2.32	541	187	21	8	10	9	776
Hertford County	92.62	1.64	168	58	12	1	3	2	244
Mount Vernon CC	97.22	0.93	174	36	2	1	1	2	216
Satellite Dialysis	98.57	1.43	58	11	0	1	0	0	70
OUTPATIENTS TOTAL	**95.14**	**1.47**	**1827**	**563**	**66**	**14**	**23**	**19**	**2512**

Trust Targets	% Would recommend	% response rate
Inpatients/Day Case	95%>	40%>
A&E	80%>	15%>
Maternity (combined)	93%>	30%>
Outpatients	94%>	N/A

Key Performance Indicators Reported to RAQC														
2016/17		Financial Year 2016-17												
		April	May	June	July	August	September	October	November	December	January	February	March	Current Position YTD
Patient Incidents	RIDDOR incidents	0	0	0	0	0								0
Patient Incidents	H&S public liability claims	1	0	1	0	0								2
Patient Incidents	Slips, Trips & Falls (not including inpatient falls)	0	0	1	1	0								2
Patient Incidents	Physical assault	1	0	1	0	0								2
Visitor Incidents	RIDDOR incidents	0	0	1	0	0								1
Visitor Incidents	H&S public liability claims	0	0	0	0	0								0
Visitor Incidents	Slips, Trips & Falls	6	7	3	6	0								22
The Workforce (Including Contractors) Incidents	RIDDOR incidents	0	2	2	3	3								10
The Workforce (Including Contractors) Incidents	Slips, Trips & Falls	4	2	5	4	7								22
The Workforce (Including Contractors) Incidents	Employer liability claims	2	0	0	0	0								2
The Workforce (Including Contractors) Incidents	Sharps incidents	8	15	11	10	9								53
The Workforce (Including Contractors) Incidents	Workplace stress	4	8	3	0	6								21
The Workforce (Including Contractors) Incidents	Contact dermatitis/latex	0	0	0	0	0								0
The Workforce (Including Contractors) Incidents	Musculoskeletal injuries	5	2	7	4	10								28
The Workforce (Including Contractors) Incidents	Physical assault	3	10	4	7	11								35
The Workforce (Including Contractors) Incidents	H & S training (Compliance) (YTD = Latest Available Position)	86%	89%	87%	87%	87%								87%
The Workforce (Including Contractors) Incidents	Significant workplace fires	0	0	0	0	0								0
The Workforce (Including Contractors) Incidents	Total Staff	5301	5310	5470	5517	5509								5509

Floodlight Health & Safety Metrics

The Rate is the percentage of incident per 1000 employees

Green is the output rate from last years figures, Amber is plus 5% and red is plus 10%

H & S Indicator		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Average monthly total
RIDDOR Incidents		0	2	2	3	3	0	0	0	0	0	0	0	10
RATE %	Red < 0.61 Amber 0.61-0.56 Green > 0.56	0.000	0.377	0.366	0.544	0.545	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.369
Slips, Trips and Falls		4	2	5	4	7	0	0	0	0	0	0	0	22
RATE %	Red < 1.28 Amber 1.28-1.18 Green >1.18	0.755	0.377	0.914	0.725	1.271	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.812
Sharps Injuries		8	15	11	10	9	0	0	0	0	0	0	0	53
RATE %	Red < 0.62 Amber 0.62-0.57 Green > 0.57	1.509	2.825	2.011	1.813	1.634	0.000	0.000	0.000	0.000	0.000	0.000	0.000	1.955
Mgr Referrals to OH for Stress		4	8	3	0	6	0	0	0	0	0	0	0	21
RATE %	Red < 0.62 Amber 0.62-0.57 Green > 0.57	0.755	1.507	0.548	0.000	1.089	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.775
Work related Musculoskeletal Injuries		5	2	7	4	10	0	0	0	0	0	0	0	28
RATE %	Red < 1.19 Amber 1.19-1.09 Green > 1.09	0.943	0.377	1.280	0.725	1.815	0.000	0.000	0.000	0.000	0.000	0.000	0.000	1.033
Physical Assault		3	10	4	7	11	0	0	0	0	0	0	0	35
RATE %	Red < 1.17 Amber 1.17-1.07 Green > 1.07	0.566	1.883	0.731	1.269	1.997	0.000	0.000	0.000	0.000	0.000	0.000	0.000	1.291
Total Staff		5301	5310	5470	5517	5509	0	0	0	0	0	0	0	27107

NURSING & MIDWIFERY QUALITY INDICATORS: Aug-1

East and North Hertfordshire NHS Trust

All data is collated using nursing & midwifery establishment figures and inpatient wards only

SUMMARY		Trust	Medicine	Surgery	Women & Children	Cancer
Beds	Total Beds	742	344	212	131	55
	Bed occupancy % (at Midnight)	83.0	94.2	78.7	67.9	64.1
e-Roastering	% E-roster Deadline Met	80.7	84.4	83.1	95.1	66.3
	Net Hours %	0.1	-0.8	-0.7	-0.7	1.5
	Net Hours Position	-1209.4	-32.1	-65.3	-28.3	45.3
	% of Actual Annual Leave	15.5	14.8	15.7	13.8	14.2
Staffing	Funded WTE	2484.4	975.8	682.3	487.8	191.0
	Actual WTE	2046.4	742.3	573.0	430.1	160.9
	Vacancy rate %	17.6	23.9	16.0	11.8	15.8
	RN Fill Rate (day shifts)	91.3	93.0	93.0	91.2	79.0
	Sickness %	5.7	6.6	5.1	4.9	8.3
	Agency usage %	16.2	22.5	15.0	7.7	11.8
	Bank usage %	11.8	13.2	9.9	7.3	6.7
	Staff Appraised % (rolling 12 months)	80.6	70.7	83.8	85.0	76.5
	Nursing Overtime	8.2	2.3	1.8	3.3	0.1
	Statutory Mandatory Training all 9 Competency %	69.7	64.1	71.0	71.5	72.5
	Statutory Mandatory Training Overall Coverage %	90.9	88.3	90.8	92.9	92.6
	No of shifts where staffing initially triggered Red	295	163	74	24	34
	% Shifts Triggered Red in Month	8.6	11.0	8.0	3.2	12.2
Patient Safety	Inpatient falls (rate per 1000 bed days)	3.8	5.3	3.3	0.7	2.9
	Inpatient falls resulting in serious harm (rate per 1000 bed days)	0.1	0.3	0.0	0.0	0.0
	Hospital Acquired Pressure Ulcers (rate per 1000 bed days)	0.0	0.1	0.0	0.0	0.0
	% News Score Completion	93.0	87.8	78.6	71.3	100.0
	News Escalation	93.0	86.9	79.7	71.8	100.0
	No. Medication Reported errors	36	16	12	7	1
	% Medication administered as prescribed	96.0	94.8	95.7	99.3	100.0
	% Analgesia administered as prescribed	96.0	88.6	99.3	92.9	100.0
	Intentional rounding completed	92.0	92.1	91.3	100.0	100.0
	Patient Identification	86.0	92.1	90.0	100	91.3
	Safety Thermometer Patients with harm	21	11	6	2	2
	% of Compliance with Hand Hygiene	97.1	91.4	99.8	99.0	99.5
Patient Experience	% Response to Inpatient Survey	35.5	49.7	39.4	25.6	19.1
	Help to eat meals/Infant Feeding	91	88.6	89.0	91.8	87.7
	Enough nurses on duty	80	74.1	79.3	91.7	83.7
	Respond to call bell	73	68.5	70.7	76.0	85.0
	Pain Control	94	94.4	92.3	90.7	94.0
	Understand answers from nurses	92	91.4	88.6	95.3	96.3
	Someone to talk to about worries and fears	83	83.2	77.0	81.3	75.0
	Enough emotional support from staff	88	87.3	81.9	89.8	89.3
	Know named nurse	75	73.0	72.6	86.7	79.0
	Inpatient FFT - % of patients would recommend	96.5	96.4	97.4	86.4	100.0
	Inpatient FFT - % of patients would not recommend	1.1	1.3	0.7	4.0	0.0
	FFT Response Rate %	44.1	53.9	43.8	31.1	24.2
	No.of Complaints	18	8	6	4	0

NURSING & MIDWIFERY QUALITY INDICATORS: Aug-16

East and North Hertfordshire NHS Trust

	Medicine	7AN	Acute Medical Unit (AMU) - Ward	Acute Cardiac Unit (Lister)	Ashwell (AAU)	Barley	Pirton	SSU	6A	6B	10B	9A	9B	11A
NURSING & MIDWIFERY	**Total Beds** (Based on wards in this report)	14	24	34	28	22	20	28	30	25	30	30	30	29
	Bed occupancy % (at Midnight)	93.3	87.1	98.3	96.3	95.7	84.8	88.4	99.9	92.9	95.7	97.8	91.8	97.1
e-Roastering	(%) E-roster Deadline Met	100.0	100.0	100.0	66.0	100.0	100.0	66.0	100.0	66.0	33.0	100.0	100.0	66.0
	Net Hours %	0.1	-0.4	-0.6	0.1	0.4	3.0	0.0	-0.5	-0.5	-1.0	-2.4	0.4	-1.0
	Net Hours Position	0.8	-14.4	-40.1	5.1	10.3	25.0	-0.8	-17.8	-24.8	-37.5	-98.3	13.5	-59.8
	% of Actual Annual Leave	23.2	14.4	18.4	14.9	14.7	20.5	14.3	10.5	12.8	16.4	13.7	13.5	10.9
Staffing	Funded WTE	18.6	62.5	54.7	31.7	30.1	41.9	35.3	36.3	37.2	33.7	35.1	35.1	35.1
	Actual WTE	12.7	45.0	47.3	23.8	16.0	22.0	31.8	23.9	36.7	24.7	26.1	26.9	26.6
	Vacancy rate %	31.8	28.1	13.6	24.8	46.9	47.4	9.8	34.2	1.6	26.9	25.6	23.3	24.3
	RN Fill Rate (day shifts)	62.6	87.7	94.2	90.1	89.2	80.3	89.0	94.8	94.1	93.3	99.8	91.6	93.0
	Sickness %	0.7	7.1	5.3	4.3	6.8	6.1	14.2	12.7	9.8	10.7	3.0	2.2	7.8
	Agency usage %	29.4	24.7	17.6	27.0	34.2	17.6	17.8	32.4	9.9	19.3	24.8	25.7	18.7
	Bank usage %	14.1	17.7	11.3	11.8	15.1	13.1	13.9	11.0	6.7	16.1	7.4	11.5	17.3
	Staff Appraised % (rolling 12 months)	62.5	57.6	43.9	100.0	86.7	64.7	87.5	41.7	62.5	78.3	100.0	66.7	55.0
	Nursing Overtime	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.5	0.0	0.0
	Statutory Mandatory Training all 9 Competency %	81.8	46.8	46.3	53.9	38.9	60.0	55.9	41.7	40.5	60.0	75.0	60.7	75.9
	Statutory Mandatory Training Overall Coverage %	96.9	83.2	84.4	86.9	73.6	72.5	91.2	75.7	77.7	84.3	92.6	89.0	94.8
	No of shifts where staffing initially triggered Red	17	11	4	4	6	13	19	14	11	13	1	16	8
	% Shifts Triggered Red in Month	18.3	11.8	4.3	4.3	6.5	14.0	20.4	15.1	11.8	14.0	1.1	17.2	8.6
Patient Safety	Inpatient falls (rate per 1000 bed days)	0.0	2.7	6.6	6.9	4.4	4.8	4.6	6.5	1.3	10.8	2.2	3.2	3.3
	Inpatient falls resulting in serious harm (rate per 1000 bed days)	0.0	0.0	0.9	0.0	0.0	0.0	2.3	0.0	0.0	0.0	0.0	0.0	0.0
	Hospital Acquired Pressure Ulcers (rate per 1000 bed days)	0.0	0.0	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	% News Score Completion	95.0	100.0	90.0	70.0	100.0	100.0	95.0	100.0	96.0	100.00	100.00	0.00	95.00
	News Escalation	94.0	100.0	100.0	57.0	89.0	100.0	100.0	90.0	100.0	100.0	100.0	0.0	100.0
	No. Medication Reported errors	1	3	4	1	1	0	0	0	1	3	0	2	0
	% Medication administered as prescribed	84.0	100.0	89.0	80.0	89.0	100.0	100.0	95.0	95.0	100.0	100.0	100.0	100.0
	% Analgesia administered as prescribed	100.0	67.0	71.0	92.0	80.0	56.0	100.0	100.0	100.0	100.0	100.0	100.0	86.0
	Intentional rounding completed	100.0	100.0	90.0	81.0	95.0	93.0	100.0	95.0	85.0	68.0	90.0	100.0	100.0
	Patient Identification	98.0	76.0	87.0	91.0	95.0	93.0	88.0	94.0	100.0	96.0	86.0	93.0	100.0
	Safety Thermometer Patients with harm	0	0	0	2	0	0	0	1	1	3	2	2	0
	% of Compliance with Hand Hygiene	100.0	100.0		68.1	80.0	100.0	92.8	75.9	96.3	100.0	96.7	95.4	
Patient Experience	% Response to Inpatient Survey	89.5	34.7	28.8	63.4	40.4	54.0	50.3	21.9	41.4	17.6	80.4	89.7	100.0
	Help to eat meals	81	100	86	90	80	91	100	92	75	75	96	89	97
	Enough nurses on duty	88	66	84	67	83	96	79	57	79	27	72	84	81
	Respond to call bell	67	75	74	60	60	75	71	67	67	58	67	68	81
	Pain Control	96	100	96	96	85	94	89	91	93	100	94	94	99
	Understand answers from nurses	87	97	88	88	81	95	95	92	87	92	94	94	98
	Someone to talk to about worries and fears	82	100	75	81	75	81	80	78	78	80	91	83	97
	Enough emotional support from staff	90	97	85	71	75	94	85	81	85	78	97	98	99
	Know named nurse	78	62	81	75	47	76	71	79	83	65	73	62	97
	Inpatient FFT - % of patients would recommend	97.1	97.9	95.6	100.0	91.3	98.1	94.7	88.9	95.8	76.9	100.0	100.0	100.0
	Inpatient FFT - % of patients would not recommend	0.0	0.0	2.2	0.0	0.0	0.0	1.3	7.4	0.0	15.4	0.0	0.0	0.0
	FFT Response Rate %	89.5	38.7	28.8	63.4	48.9	85.7	50.3	42.2	41.4	17.6	78.3	89.7	100.0
	No.of Complaints	1	0	2	1	0	0	2	1	0	0	0	1	0

NURSING & MIDWIFERY QUALITY INDICATORS: Aug-16

East and North Hertfordshire NHS Trust

Section	Surgery	Critical Care	Swift	5A	5B	7B	8A	8B	11B
NURSING & MIDWIFERY QUALITY	**Total Beds** (Based on wards in this report)	19	25	30	30	15	54	24	15
	Bed occupancy % (at Midnight)	72.5	83.9	89.7	84.5	100.0	50.5	100.0	90.1
e-Roastering	% E-roaster Deadline Met	100.0	100.0	100.0	100.0	33.0	100.0	66.0	66.0
	Net Hours %	-3.4	0.7	1.4	-1.1	-1.6	-0.1	-2.3	1.7
	Net Hours Position	-457.8	33.3	56.8	-38.0	-60.0	-3.2	-68.8	53.1
	% of Actual Annual Leave	15.8	13.9	16.4	15.9	16.3	13.4	13.0	20.7
Staffing	Funded WTE	93.5	31.7	33.1	35.3	31.2	34.1	34.1	26.4
	Actual WTE	87.4	21.5	24.6	22.6	21.6	25.1	21.5	21.9
	Vacancy rate %	6.4	30.2	25.8	35.8	28.1	26.3	37.0	17.2
	RN Fill Rate (day shifts)	100.0	91.8	92.8	94.7	89.1	97.3	83.7	94.9
	Sickness %	3.8	5.1	1.4	7.7	10.1	1.0	14.7	8.0
	Agency usage %	0.0	10.0	21.0	13.2	24.6	26.0	40.1	9.6
	Bank usage %	0.0	18.5	16.0	21.0	11.1	9.5	6.9	17.4
	Staff Appraised % (rolling 12 months)	98.8	87.0	100.0	96.0	42.1	85.7	76.9	89.5
	Nursing Overtime	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Statutory Mandatory Training all 9 Competency %	74.7	66.7	37.0	74.1	43.5	88.0	47.6	76.0
	Statutory Mandatory Training Overall Coverage %	93.3	92.8	82.9	93.4	91.7	98.7	87.1	94.3
	No of shifts where staffing initially triggered Red	0	2	8	19	12	2	21	4
	% Shifts Triggered Red in Month	0.0	2.2	8.6	20.4	12.9	2.2	22.6	4.3
Patient Safety	Inpatient falls (rate per 1000 bed days)	1.7	3.9	2.2	8.6	6.5	2.4	1.3	0.0
	Inpatient falls resulting in serious harm (rate per 1000 bed days)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Hospital Acquired Pressure Ulcers (rate per 1000 bed days)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	% News Score Completion		0.0	90.0	70.0	95.0	100.0	100.0	95.0
	News Escalation		0.0	88.0	78.0	100.0	92.0	100.0	100.0
	No. Medication Reported errors	4	1	3	1	0	2	1	0
	% Medication administered as prescribed	100.0	100.0	95.0	85.0	100.0	95.0	100.0	95.0
	% Analgesia administered as prescribed	100.0	100.0	100.0	95.0	100.0	100.0	100.0	100.0
	Intentional rounding completed	100.0	100.0	100.0	100.0	95.0	85.0	79.0	80.0
	Patient Identification	90.0	100.0	84.0	79.0	100.0	87.0	94.0	86.0
	Safety Thermometer Patients with harm	2	0	1	2	0	0	1	0
	% of Compliance with Hand Hygiene	100.0	100.0	100.0	100.0	100.0	98.6	100.0	100.0
Patient Experience	% Response to Inpatient Survey		46.6	38.5	80.0	37.4	19.1	33.6	51.5
	Help to eat meals/Infant Feeding	100	84	85	93	94	92	75	100
	Enough nurses on duty	100	85	78	67	84	88	65	88
	Respond to call bell	88	67	80	55	72	70	73	78
	Pain Control	100	91	88	96	98	92	85	96
	Understand answers from nurses	100	90	82	89	95	81	91	92
	Someone to talk to about worries and fears	100	84	76	88	85	75	52	79
	Enough emotional support from staff	100	88	80	91	87	75	70	82
	Know named nurse	88	72	72	81	72	77	51	83
	Inpatient FFT - % of patients would recommend		92.9	100.0	91.7	97.0	96.2	80.6	96.1
	Inpatient FFT - % of patients would not recommend		1.2	0.0	4.2	0.0	3.8	8.3	0.0
	FFT Response Rate %	0.0	45.0	38.5	80.0	36.8	19.1	33.6	51.5
	No.of Complaints	0	2	1	0	2	0	1	0

Section	Women and Children	CLU	Dacre	Gloucester	MLU	Bluebell	Neonatal Unit	7A
NURSING & MIDWIFERY QUALITY	**Total Beds** (Based on wards in this report)	10	21	27	8	20	30	15
	Bed occupancy % (at Midnight)	100.0	52.4	89.2	37.5	68.5	46.9	87.1
e-Roastering	% E-roaster Deadline Met	100.0	100.0	100.0	100.0	66.0	100.0	100.0
	Net Hours %	-0.7	-0.4	0.5	-0.6	-3.5	0.4	1.2
	Net Hours Position	-12.0	-9.0	8.5	-64.1	-126.9	14.1	60.9
	% of Actual Annual Leave	15.2	9.0	17.5	15.0	12.7	16.6	15.5
Staffing	Funded WTE	72.9	19.1	37.1	21.4	31.7	65.8	39.1
	Actual WTE	81.0	14.7	29.1	20.7	22.6	58.2	34.7
	Vacancy rate %	-11.1	23.1	21.7	3.1	28.8	11.6	11.2
	RN Fill Rate (day shifts)	99.1	86.4	98.2	92.3	85.7		85.3
	Sickness %	4.7	16.5	6.9	2.1	2.4	5.3	6.9
	Agency usage %	3.4	14.5	12.7	0.1	28.2	0.0	10.3
	Bank usage %	3.9	0.0	13.6	3.1	11.1	12.0	5.7
	Staff Appraised % (rolling 12 months)	85.9	66.7	96.7	81.5	73.7	94.3	92.0
	Nursing Overtime	0.0	0.0	0.1	0.0	0.0	0.7	0.0
	Statutory Mandatory Training all 9 Competency %	72.0	77.8	77.8	60.0	45.5	76.2	77.8
	Statutory Mandatory Training Overall Coverage %	95.8	96.6	91.9	87.1	86.0	94.6	93.9
	No of shifts where staffing initially triggered Red	3	2	1	2	7	0	4
	% Shifts Triggered Red in Month	3.2	2.2	1.1	2.2	7.5	0.0	4.3
Patient Safety	Inpatient falls (rate per 1000 bed days)	0.0	0.0	0.0	0.0	0.0	0.0	6.5
	Inpatient falls resulting in serious harm (rate per 1000 bed days)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Hospital Acquired Pressure Ulcers (rate per 1000 bed days)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	% News Score Completion	Not applicable	100.0	85.0	Not applicable	0.0	Not applicable	100.0
	News Escalation	Not applicable	100.0	100.0	Not applicable	0.0	Not applicable	87.0
	No. Medication Reported errors	1	3	0	1	0	1	1
	% Medication administered as prescribed	100.0	100.0	100.0	100.0	100.0	95.0	100.0
	% Analgesia administered as prescribed	100.0	100.0	100.0	100.0	100.0	50.0	100.0
	Intentional rounding completed							100.0
	Patient Identification							100
	Safety Thermometer Patients with harm	0				0	0	2
	% of Compliance with Hand Hygiene	100.0	100.0	100.0	100.0		100.0	94.2
Patient Experience	% Response to Inpatient Survey	0.0				1.5	0.0	49.1
	Help to eat meals/Infant Feeding	84				100	100	83
	Enough nurses on duty	94				100		81
	Respond to call bell							76
	Pain Control	84				100		88
	Understand answers from nurses	95				100	100	86
	Someone to talk to about worries and fears	76				100		68
	Enough emotional support from staff	93				100	92	74
	Know named nurse					100	92	68
	Inpatient FFT - % of patients would recommend					100	100	80
	Maternity FFT - % of patients would recommend - Antenatal	96.2				Not applicable		
	Maternity FFT - % of patients would recommend - Birth	95.8				Not applicable		
	Maternity FFT - % of patients would recommend - Postnatal	92.0				Not applicable		
	Maternity FFT - % of patients would recommend - Community Midwifery	83.3				Not applicable		
	Inpatient FFT - % of patients would not recommend	Not applicable				0.0	0.0	6.3
	Maternity FFT - % of patients would not recommend - Antenatal	0.0				Not applicable		
	Maternity FFT - % of patients would not recommend - Birth	0.8				Not applicable		
	Maternity FFT - % of patients would not recommend - Postnatal	1.3				Not applicable		
	Maternity FFT - % of patients would not recommend - Community Midwifery	0.0				Not applicable		
	Inpatient FFT Response Rate %	26.2				10.7	42.9	48.5
	Maternity FFT Response Rate % - Combined	26.5				Not applicable		
	No.of Complaints	1	0	0	2	1	0	0

CANCER		Ward 10	Ward 11	Michael Sobell House
Beds	Total Beds (Based on wards in this report)	21	18	16
	Bed occupancy % (at Midnight)	57.0	71.3	65.3
e-Roastering	% E-roaster Deadline Met	100.0	33.0	66.0
	Net Hours %	0.0	4.0	-0.4
	Net Hours Position	0.0	28.5	-9.4
	% of Actual Annual Leave	0.0	13.6	12.1
Staffing	Funded WTE	27.2	26.8	26.2
	Actual WTE	17.7	20.0	26.2
	Vacancy rate %	34.9	25.3	-0.2
	RN Fill Rate (day shifts)	55.2	79.5	102.3
	Sickness %	27.3	12.1	7.7
	Agency usage %	17.2	8.5	9.4
	Bank usage %	6.5	11.4	2.1
	Staff Appraised % (rolling 12 months)	66.7	76.5	93.1
	Nursing Overtime	0.0	0.0	0.0
	Statutory Mandatory Training all 9 Competency %	68.4	70.0	72.7
	Statutory Mandatory Training Overall Coverage %	94.7	95.0	92.9
	No of shifts where staffing initially triggered Red	18	13	3
	% Shifts Triggered Red in Month	19.4	14.0	3.2
Patient Safety	Inpatient falls (rate per 1000 bed days)	4.6	1.8	2.0
	Inpatient falls resulting in serious harm (rate per 1000 bed days)	0.0	0.0	0.0
	Hospital Acquired Pressure Ulcers (rate per 1000 bed days)	0.0	0.0	0.0
	% News Score Completion	100.0	100.0	
	News Escalation	100.0	100.0	
	No. Medication Reported errors	0	1	0
	% Medication administered as prescribed	100.0	100.0	100.0
	% Analgesia administered as prescribed	100.0	100.0	100.0
	Intentional rounding completed	100.0	100.0	
	Patient Identification	80.0	94.0	100.0
	Safety Thermometer Patients with harm	1	0	1
	% of Compliance with Hand Hygiene	100.0	98.4	100.0
Patient Experience	% Response to Inpatient Survey	9.3	12.9	46.6
	Help to eat meals	83	80	100
	Enough nurses on duty	78	73	100
	Respond to call bell	89	66	100
	Pain Control	93	89	100
	Understand answers from nurses	93	96	100
	Someone to talk to about worries and fears	50	75	100
	Enough emotional support from staff	75	93	100
	Know named nurse	56	81	100
	Inpatient FFT - % of patients would recommend	100.0	100.0	100.0
	Inpatient FFT - % of patients would not recommend	0.0	0.0	0.0
	FFT Response Rate %	9.3	12.9	69.0
	No.of Complaints	0	0	0

KPI Definitions July 2016

Theme	Measure	Metric	Goal (at which point a Green rating is applied)	Threshold (after which point a Red rating is applied)	Direction	Data Source / Data Owner	Reporting Scope	Noted Issue	Comments
Beds	Total beds	A simple count of inpatient beds, excluding trolleys and assessment areas for each ward unit.	n/a	n/a	n/a	Manual data collection/ Bed Management Team	Aggregated to Trust and Division from the ward unit of analysis		
	Bed occupancy	The percentage of inpatient bed days occupied by a patient at Midnight (Review in line with Trust level reporting)	90%	95%	Lower values are better	Acumen / Information Team	Aggregated to Trust and Division from the ward unit of analysis	Green <= 90%, Amber <=95%, Red > 95%	If not supplied then set as Not Applicable
e-Rostering	% E-roaster Deadline Met	The percentage of approval and finalisation deadlines met in month. Each roster must be approved by the Ward Manager, Payroll and the Matron for which equal weighting is applied to when assessing full compliance.	100%	<100%	Not defined	MAPS / Rupert Clarke	Agregated to Trust and Division from the ward unit of analysis	Green = 100%, Red > 100%	If not supplied then set as Not Provided and Red
	Net Hours Position	The Net hour position for the last 4-week roster to fall in the month.	As Above	As Above	Not defined	MAPS / Rupert Clarke	Agregated to Trust and Division from the ward unit of analysis		If not supplied then set as Not Provided and Red
	Net Hours %	The % Net hour position for the last 4 week roster to fall in the month.	<>2.0% swing ing the total contracted hours for the ward	<>2.5% swing ing the total contracted hours for the ward		MAPS / Rupert Clarke			If not supplied then set as Not Provided and Red
	% of Actual Annual Leave	The percentage for annual leave in the last four-week roster to fall in the month	>=11% <=17%	<10% >18%	Not defined	MAPS / Rupert Clarke	Agregated to Trust and Division from the ward unit of analysis	??	If not supplied then set as Not Provided and Red
	Funded WTE	A simple count of the ward's funded working hours expressed in terms of whole time equivalents	n/a	n/a	Not applicable	ESR / Lindsay Freeston	Aggregated to Trust and Division from the ward unit of analysis		If not supplied then set as Not Applicable
	Actual WTE	A simple count of the hours worked by the ward's workforce expressed in terms of whole time equivalents	n/a	n/a	Not applicable	ESR / Lindsay Freeston	Aggregated to Trust and Division from the ward unit of analysis		If not supplied then set as Not Applicable

KPI Definitions July 2016

Theme	Measure	Metric	Goal (at which point a Green rating is applied)	Threshold (after which point a Red rating is applied)	Direction	Data Source / Data Owner	Reporting Scope	Noted Issue	Comments
Staffing	Vacancy rate %	The percentage of funded working hours remaining after subtracting the contracted working hours from the ward establishment.	10%	12%	Lower values are better	ESR / Lindsay Freeston	Aggregated to Trust and Division from the ward unit of analysis	Green <= 10.5%, Amber <=11.5%, Red > 11.5%	
	RH Fill Rate (day shifts)	The number of actual worked hours (including overtime) divided by the total planned working hours expressed as a percentage	90%	85%	Not defined	MAPS / Rupert Clarke	Agregated to Trust and Division from the ward unit of analysis	Green <= 90%, Amber <=85%, Red > 85%	If not supplied then set as Not Provided and Red
	Sickness %	The number of reported sick days expressed as a percentage of the total working calendar days in month	3.5%	4%	Lower values are better	ESR / Lindsay Freeston	Aggregated to Trust and Division from the ward unit of analysis	Green <= 3.75%, Amber <=4%, Red > 4%	
	Agency usage %	To be confirmed to align with Trust Floodlights	2%	5%	Lower values are better	General Ledger / Lisa Potter	Aggregated to Trust and Division from the ward unit of analysis	Green <= 2%, Amber <=5%, Red > 5%	
	Bank usage %	To be confirmed to align with Trust Floodlights	4%	7%	Lower values are better	General Ledger / Lisa Potter	Aggregated to Trust and Division from the ward unit of analysis	Green <= 4%, Amber <=7%, Red > 7%	
	Staff Appraised % (rolling 12 months)	To be confirmed to align with Trust Floodlights	85%	80%	Higher values are better	ESR / Lindsay Freeston	Aggregated to Trust and Division from the ward unit of analysis	Green >= 85%, Amber >=80%, Red < 80%	
	Statutory Mandatory Training Overall Coverage %	The percentage of the ward staff in post who are fully compliant with their individual Statutory Training compliance framework.	90%	80%	Higher values are better	ESR data extract / Lindsay Freeston.	Aggregated to Trust and Division from the ward unit of analysis	Green >= 90%, Amber >=80%, Red < 80%	
	Statutory Mandatory Training all 9 Competency %	The percentage of the ward staff in post who are fully compliant with all 9 Statutory Training compliance framework.							Never RAG Rate
Staffing (cont.)	No of shifts where staffing initially fell below agreed levels	The count of shifts on a ward where staffing initially fell below agreed levels	n/a	n/a	n/a	Safer Staffing Report / Adam Brown	Aggregated to Trust and Division from the ward unit of analysis	No thresholds set. Metric displayed for context.	If not supplied then set as Not Provided and Red
	% Shifts Triggered Red in Month	The % shifts on wards triggering red - where staffing levels are judged to be below minimum required levels - in month	0%	10%	Lower values are better	Safer Staffing Report / Rupert Clarke	Aggregated to Trust and Division from the ward unit of analysis	Green = 0, Amber >0, Red >10	If not supplied then set as Not Provided and Red
	% Shifts Unmitigated Red in Month	The % shifts on wards remaining red where staffing levels are judged to be below minimum required levels - in month	0%	5%	Lower values are better	Safer Staffing Report / Rupert Clarke	Aggregated to Trust and Division from the ward unit of analysis	Green = 0, Amber >0, Red >5	If not supplied then set as Not Provided and Red

KPI Definitions July 2016

Theme	Measure	Metric	Goal (at which point a Green rating is applied)	Threshold (after which point a Red rating is applied)	Direction	Data Source / Data Owner	Reporting Scope	Noted Issue	Comments
Patient Safety	No. Inpatient falls	Inpatient falls in month reported per 1000 bed days	3.17	3.30	Lower values are better	Manual data collection / Edna Gallagher	Aggregated to Trust and Division from the ward unit of analysis. Thresholds set at Trust level only	Green >= 3.17, Amber >=3.3, Red < 3.3	If not supplied then set as zero
	No. Inpatient falls resulting in serious harm	Inpatient falls in month resulting in serious harm reported per 1000 bed days	0.76	0.80	Lower values are better	Manual data collection / Edna Gallagher	Aggregated to Trust and Division from the ward unit of analysis. Thresholds set at Trust level only	Green >= 0.76, Amber >=0.8, Red < 0.8	If not supplied then set as zero
	No. Pressure ulcers ≥2	Number of confirmed grade 2 and above pressure ulcers in month reported per 1000 bed days	0.16	0.21	Lower values are better	Manual data collection / Dianne Brett	Aggregated to Trust and Division from the ward unit of analysis. Thresholds set at Trust level only	Green >= 0.16, Amber >=0.21, Red < 0.21	If not supplied then set as zero
Patient Safety (cont.)	NEWS score	Observations assessed against the Early Warning Score (EWS) in accordance with Trust guidelines	98%	89%	Higher values are better	Meridian	Scores shown for wards completing required number of audits (usually 20 per month). All Audits counted towards Divisional and Trust score	Green >= 98%, Amber >=89%, Red < 89%	If not supplied then set as Not Provided and Red. Not Applicable to Michael Sobell House
	NEWS Escalation	Documentation of referral to medical staff for patients assessed as being at risk.	98%	89%	Higher values are better	Meridian	Aggregated to Trust and Division from the ward unit of analysis	Green >= 98%, Amber >=89%, Red < 89%	If not supplied then set as Not Provided and Red. Not Applicable to Michael Sobell House
	No. Medication Reported errors	The count of reported medication administration errors in month	n/a	n/a	Lower values are better	Electronic data collection by Datix Incident Forms / Phil James and Diane Moore	Aggregated to Trust and Division from the ward unit of analysis. Thresholds set at Trust level only		If not supplied then set as zero
	% Medication administered as prescribed	Medicines administered and signed for in accordance with the prescriptoin over the last 7 days	>95%	89%	Higher values are better	Meridian	Aggregated to Trust and Division from the ward unit of analysis	Green >= 95%, Amber >=89%, Red < 89%	If not supplied then set as Not Provided and Red

KPI Definitions July 2016

Theme	Measure	Metric	Goal (at which point a Green rating is applied)	Threshold (after which point a Red rating is applied)	Direction	Data Source / Data Owner	Reporting Scope	Noted Issue	Comments
Patient Safety (cont.)	% Analgesia administered as prescribed	If patient experienced pain in the last 24 hours is it documented that analgesia given within 30 minutes of the complaint of pain.	>95%	89%	Higher values are better	Meridian	Aggregated to Trust and Division from the ward unit of analysis	Green >= 95%, Amber >=89%, Red < 89%	If not supplied then set as Not Provided and Red
Patient Safety (cont.)	Intentional rounding completed	Intentional rounding chart completed correctly for last 24 hours.	>95%	89%	Higher values are better	Meridian	Aggregated to Trust and Division from the ward unit of analysis	Green >= 95%, Amber >=89%, Red < 89%	If not supplied then set as Not Provided and Red. Not Applicable to Michael Sobell House
Patient Safety (cont.)	Safety Thermometer Patients with harm	A count of patients suffering harm as defined in the Safety Thermometer audit	<=381	>=382	Lower values are better	Safety Thermometer Audit / Jenny Pennell	Aggregated to Trust and Division from the ward unit of analysis. Thresholds set at annual Trust level only	*** Need to set target per month *** then will set on Trust Floodlights	If not supplied then Not Applicable
Patient Safety (cont.)	% Compliance with Hand Hygiene		>95%	<=89%	Higher values are better	Meridian		Green >= 95%, Amber >=89%, Red < 89%	If not supplied then set as Not Provided and Red
Patient Experience	% Response rate to patient experience survey	Percentage response rate to patient experience survey (inpatient, maternity, neonatal, critical care) from eligible patients	>=25%	<25%	Higher values are better	Meridian Inpatient experience survey/Jenny Pennell. Acumen / Information Team	Applies over all levels for Ward and Trust etc	Green >= 25%, Red < 25%	If data not supplied then set to Not Provided. Not Applicable for **ASCU**.
Patient Experience	Help with Meals	Reported patient experience score out of 100. Inpatients & Critical Care: Did you get enough help from staff to eat your meals? Maternity: Thinking about feeding your baby	>=67	<=56	Higher values are better	Meridian Patient Experience Survey / Jenny Pennell	Aggregated to Trust and Division from the ward unit of analysis	Green >= 67, Amber >= 56, Red < 56	If not supplied then set as Not Provided and Red. **ACSU** is not applicable if data not supplied
Patient Experience	Enough nurses on duty	Reported patient experience score out of 100. Inpatients: In your opinion, were there enough nurses on duty to care for you in hospital? Maternity: Were you left alone by staff at a time when it worried you?	>=84	<=73	Higher values are better	Meridian Patient Experience Survey / Jenny Pennell	Aggregated to Trust and Division from the ward unit of analysis	Green >= 84, Amber >= 73, Red < 73	If not supplied then set as Not Provided and Red. Not Applicable to **Critical Care** and **Neonatal**.

KPI Definitions July 2016

Theme	Measure	Metric	Goal (at which point a Green rating is applied)	Threshold (after which point a Red rating is applied)	Direction	Data Source / Data Owner	Reporting Scope	Noted Issue	Comments
Patient Experience (cont..)	Respond to call bell	Reported patient experience score out of 100. Inpatients and Critical Care: After you used the call button, how long did it usually take before you got help?	>=68	<=61	Higher values are better	Meridian Patient Experience Survey / Jenny Pennell	Aggregated to Trust and Division from the ward unit of analysis	Green >= 68, Amber >= 61, Red < 61	If not supplied then set as Not Provided and Red. Not Applicable to Maternity and Neonatal
	Pain Control	Reported patient experience score out of 100. Inpatients & Critical Care: Do you think the hospital staff did everything they could to help control your pain? Maternity: During labour and birth, did you feel you got the pain relief you wanted?	>=86	<=79	Higher values are better	Meridian Patient Experience Survey / Jenny Pennell	Aggregated to Trust and Division from the ward unit of analysis	Green >= 86, Amber >= 79, Red < 79	If not supplied then set as Not Provided and Red. Not Applicable to Neonatal.
	Someone to talk to about worries and fears	Reported patient experience score out of 100. Inpatients & Critical Care: Did you find someone on the hospital staff to talk to about your worries and fears? Maternity: Were you given the opportunity to discuss your birth experience?	>=65	<=54	Higher values are better	Meridian Patient Experience Survey / Jenny Pennell	Aggregated to Trust and Division from the ward unit of analysis	Green >= 65, Amber >= 54, Red < 54	If not supplied then set as Not Provided and Red. Not Applicable to **Neonatal**
Patient Experienc	Understand answers from nurses	Reported patient experience score out of 100. Inpatients: When you had important questions to ask a nurse, did you get answers that you could understand? Maternity: Thinking about your care during labour and birth, were you spoken to in a way you could understand? Neonatal: When you asked questions about your baby's	>=88	<=83	Higher values are better	Meridian Patient Experience Survey / Jenny Pennell	Aggregated to Trust and Division from the ward unit of analysis	Green >= 88, Amber >= 83, Red < 83	If not supplied then set as Not Provided and Red. Not Applicable to **Critical Care**.
	Enough emotional support from staff	Reported patient experience score out of 100. Inpatients: Do you feel you got enough emotional support from hospital staff during your stay? Maternity: Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding by the midwives? Neonatal: Were you offered emotional support from staff	>=78	<=67	Higher values are better	Meridian Patient Experience Survey / Jenny Pennell	Aggregated to Trust and Division from the ward unit of analysis	Green >= 78, Amber >= 67, Red < 67	If not supplied then set as Not Provided and Red. Not Applicable to **Critical Care**.

KPI Definitions July 2016

Theme	Measure	Metric	Goal (at which point a Green rating is applied)	Threshold (after which point a Red rating is applied)	Direction	Data Source / Data Owner	Reporting Scope	Noted Issue	Comments
e (cont..)	Know named nurse	Reported patient experience score out of 100. Inpatients: Do you know who your named nurse is? Critical Care: Did the staff treating and examining you introduce themselves? Neonatal: Were you told which nurse was responsible for your baby's care each day he/she was in the neonatal unit?	>=75	<=63	Higher values are better	Meridian Patient Experience Survey / Jenny Pennell	Aggregated to Trust and Division from the ward unit of analysis	Green >= 75, Amber >= 63, Red < 63	If not supplied then set as Not Provided and Red. Not applicabel to **Maternity**.
Patient Experience (cont..)	Inpatient FFT - % of patients who would recommend	The percentage of patients who are extremely likey + likely to recommend the ward to their friends and family	>=93%	<93%	Higher values are better	FFT Survey/ Jenny Pennell	Aggregated to Trust and Division from the ward unit of analysis	Green >= 93%, Red < 93%	If not supplied then set as Not Provided and Red. Not Applicable for **ASCU** & **Critical Care**. Not applicable to **CLU**, **MLU**, **Dacre** & **Gloucester** as report Maternity FFT.
	Inpatient FFT - % of patients would not recommend	The percentage of patients who are unlikey + extremely unlikely to recommend the ward to their friends and family	<=2%	>2%	Lower values are better	FFT Survey/ Jenny Pennell	Aggregated to Trust and Division from the ward unit of analysis	Green <= 2%, Red > 2%	If not supplied then set as Not Provided and Red. Not Applicable for **ASCU** & **Critical Care**. Not applicable to **CLU**, **MLU**, **Dacre** & **Gloucester** as report Maternity FFT.
	FFT Response Rate %	The percentage of patients who responded to the FFT Survey from all those eligible to respond. Maternity FFT calculated from combined response rates.	>=40%	<40%	Higher values are better	FFT Survey/ Jenny Pennell. Acumen / Information Team	Thresholds updated.	Green >= 40%, Red < 40%	

KPI Definitions July 2016

Theme	Measure	Metric	Goal (at which point a Green rating is applied)	Threshold (after which point a Red rating is applied)	Direction	Data Source / Data Owner	Reporting Scope	Noted Issue	Comments
	No.of Complaints	The count of registered complaints received in month from wards	858	942	Lower values are better	Datix / Jackie Martin and Jan Shrieves	Aggregated to Trust and Division from the ward unit of analysis. Thresholds set at annual Trust level only	*** Need to set target per month ***	If not supplied then set as zero

PERFORMANCE DATA

CQC outcomes summary

Appendix A

Summary of the Trust's CQC Registration Status across all locations.

Regulatory Activity	Lister Hospital*	New QEII	MVCC	Hertford	Bedford Renal Unit	Harlow Renal Unit
Treatment of disease, disorder or injury	Registered with conditions	Registered	Registered with conditions	Registered	Registered	Registered
Surgical Procedures	Registered	Registered	Registered with conditions			
Maternity and midwifery services	Registered with conditions	Registered		Registered		
Diagnostic and Screening procedures	Registered	Registered	Registered with conditions	Registered	Registered	Registered
Termination of Pregnancies	Registered	Registered				
Family Planning Services	Registered	Registered		Registered		
Assessment or medical treatment of people detained under the Mental Health Act 1983	Registered	Registered	Registered			

*** Lister Hospital's registration includes the registrations for renal satellite units in St Albans Hospital and Luton and Dunstable Hospital.**

Following the CQC Comprehensive Inspection in October 2015 regulatory actions were applied in March 2016. These are:

- Lister Hospital regarding compliance with regulations 12, 17 and 18. In brief the Trust must:
  - Ensure that the triage process accurately measures patient need and priority in both the emergency department and maternity services
  - Ensure records and assessments are completed in accordance with Trust Policy
  - Ensure that there are effective governance systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients
  - Ensure that all staff in all services complete their mandatory training

- Mount Vernon Cancer Centre regarding compliance with regulations 12 and 17. In brief the Trust must:
  - Ensure that patients requiring urgent transfer from Mount Vernon Cancer Centre have their needs met to ensure safety and that there are effective process to handover continuing treatment
  - Ensure there is oversight and monitoring of all transfers

A number of the actions have now been completed and are being monitored to ensure they are sustained. The aim is for all actions to be delivered by end of September 2016. Progress in complying with these regulatory actions is monitored through action plans submitted to the CQC Quality Development Programme Board on a fortnightly basis and monthly Performance Management Reviews. The Quality Development Board reports to the Risk and Quality Committee. The CQC report from the unannounced inspection in ED and Bluebell Ward in May 2016 confirms progress against the regulatory actions.

WORKFORCE APPENDICES

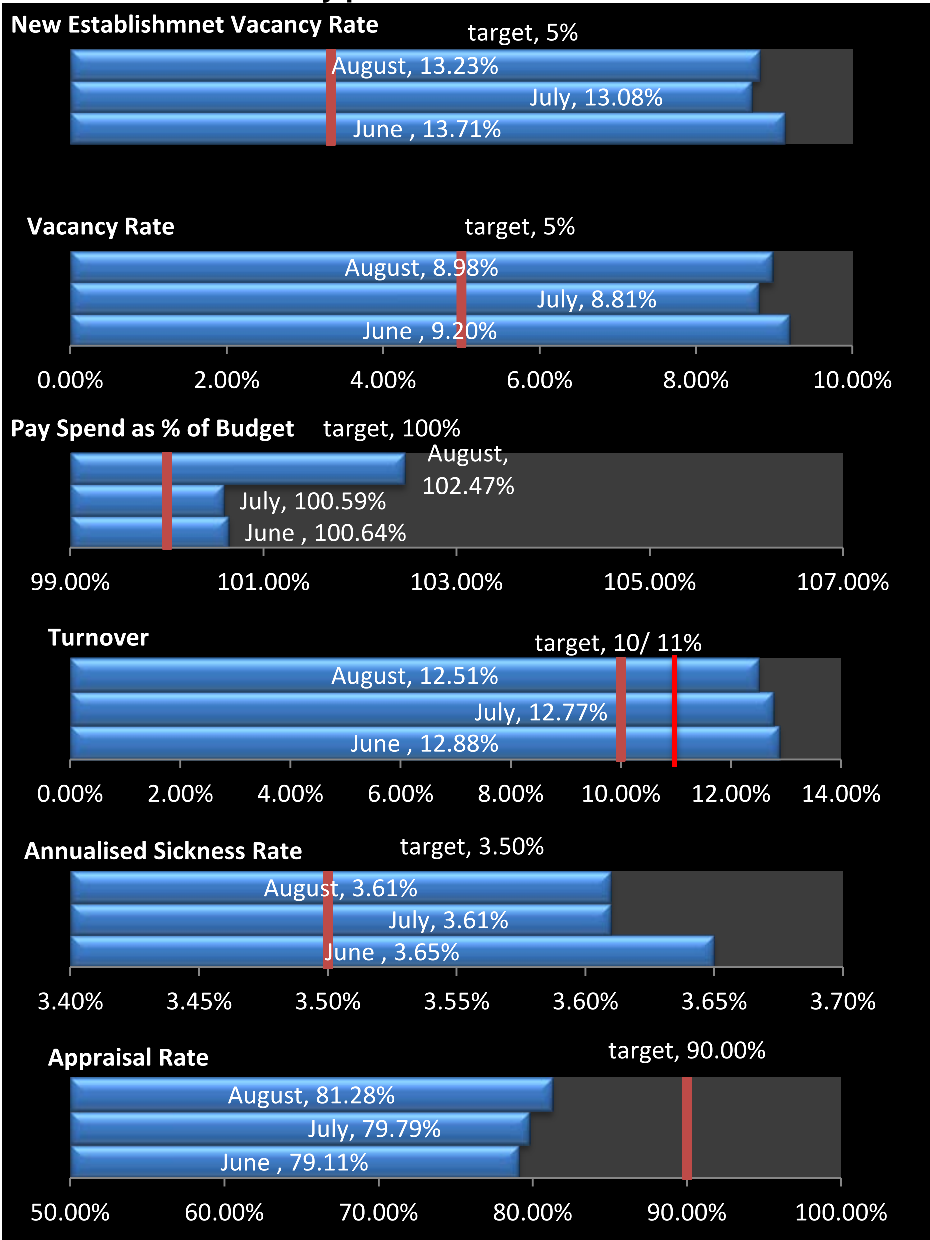
EAST AND NORTH HERTS NHS TRUST

September 2016 - Based on Month 5

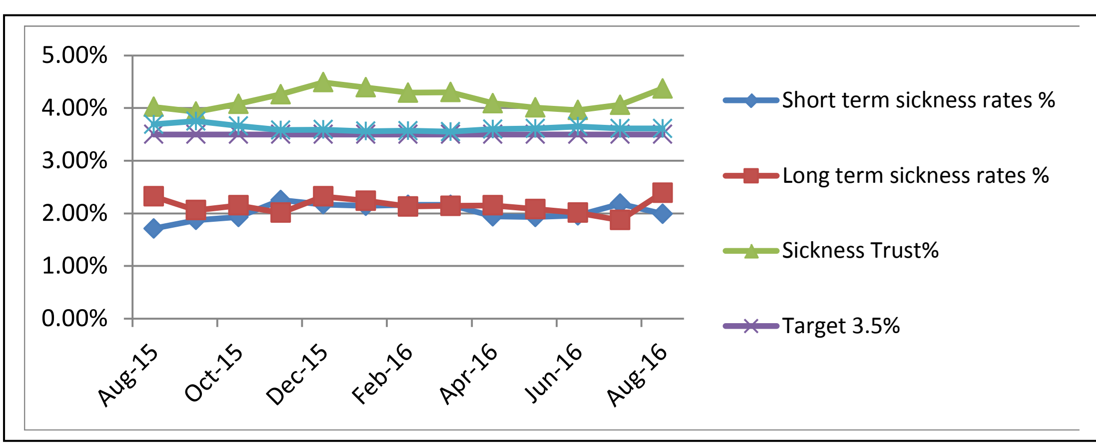
Workforce Information Report Summary

Workforce Report September 2016
(Based on data as at the end of August 2016)

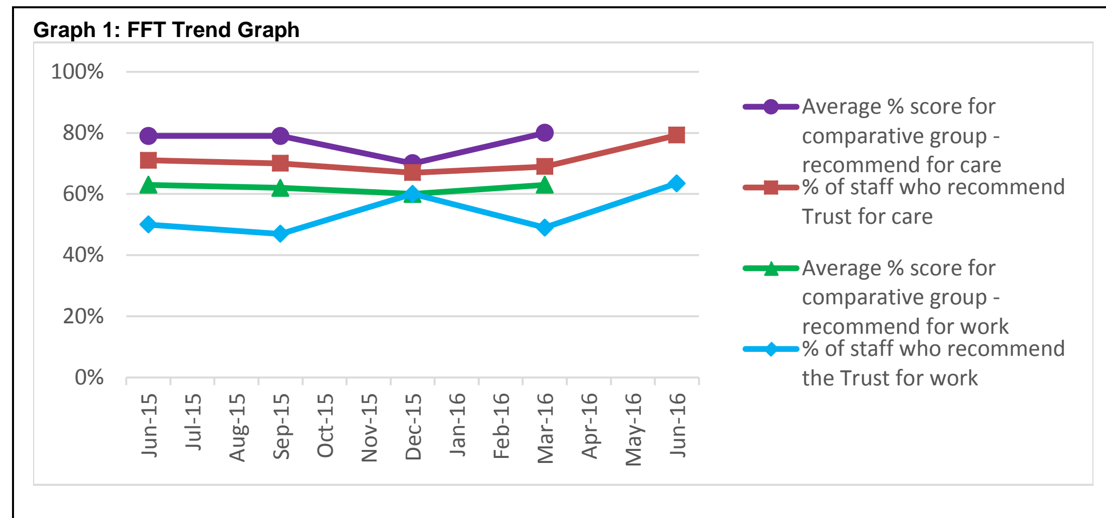
Section 1: KPI summary position



Graph 1: Sickness Rates Based On In Month Position



Section 2: Our Culture



*National benchmarks for Quarter 1 2016/17 will be published in late August 2016

Table 1: Health at Work Service core activity

Health at Work Service core activity	Average Activity 2015/16	Activity as of 31 July 2016	Activity as of 31 August 2016
Trust			
Pre Placements received	164	239	173
Manager referrals received	83	68	89
Immunisation/blood tests	554	390	362
Blood borne virus incident (sharps)	13	10	9
Return to Work plans advised	18	21	19
Self-referral advice given	17	21	22
Physiotherapy referrals	5	3	14
Use of Employee Assistance Programme	15	27	18
External			
Pre-placement	107	93	105
Manager referrals received	40	44	39
Immunisations and blood tests	341	126	151
Blood borne virus incident (sharps)	5	8	5

Section 3: Developing our people

Table 1: June 2016 Appraisal Compliance

Compliance	Done	Not Done	Not due but require review*	Grand Total	Completion Rate % June
Cancer Services	389	48	66	503	**89.02**
Clinical Support Services	511	46	132	689	**91.74**
Medicine	556	258	299	1113	**68.30**
Corporate	360	80	127	567	**81.82**
Research & Development	62	17	25	104	**78.48**
Surgery	680	166	168	1014	**80.38**
Women's and Children's	442	76	109	627	**85.33**
Grand Total	**3000**	**691**	**926**	**4617**	**81.28**

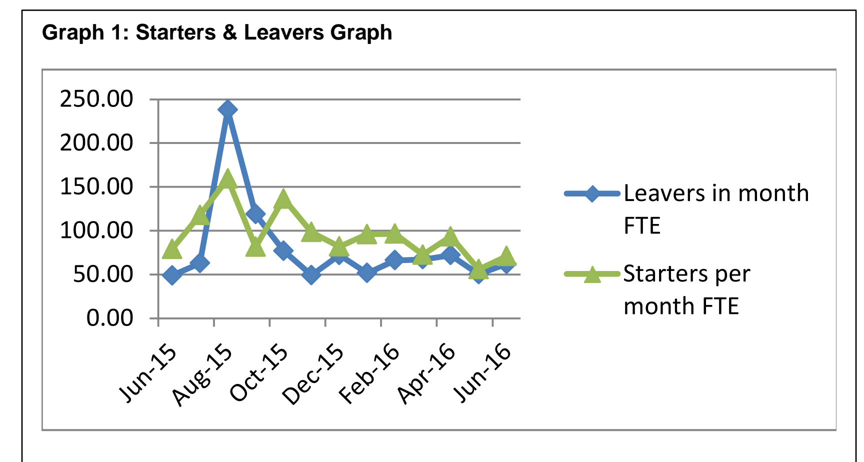


Table 2: Appraisal Compliance by Payband

Pay Band	Appraisal Completion Rate %
Band 1	82.05
Band 2	79.80
Band 3	82.38
Band 4	81.94
Band 5	79.84
Band 6	85.88
Band 7	79.86
Band 8A	83.06
Band 8B	60.00
Band 8C	77.78
Band 8D	75.00
Band 9	62.50
Snr Mgr Pay	62.50
Tupe	0.00
Grand Total	**81.28**

Table 3: Training Data

Source: ESR	Trust MTH	Surgery	Medicine	CSS	W & C	Cancer	R and D	Corporate
Statutory and mandatory training full compliance (Incl M&D)	66.00%	61.70%	56.04%	79.64%	66.85%	72.70%	75.47%	71.97%
Statutory and mandatory training average compliance (Incl M&D)	86.99%	85.50%	81.84%	92.94%	89.81%	90.81%	93.27%	86.96%

Section 4: People Performance

Table 1:Bank & Agency Spend
Graph 1: Ledger Position V Worked WTE

June 2016 position				
Total spend	**Current month**		**YTD**	
	£	**%**	**£**	**%**
Agency	2,593,283	11.90%	11,968,275	11.20%
Bank	971,924	4.50%	4,823,014	4.50%
Substantive	90,009,270	84.30%	18,140,034	83.60%
Total	**106,800,558**		21,705,241	
Variance against pay budget	522,449	2.47%	835,738	0.79%

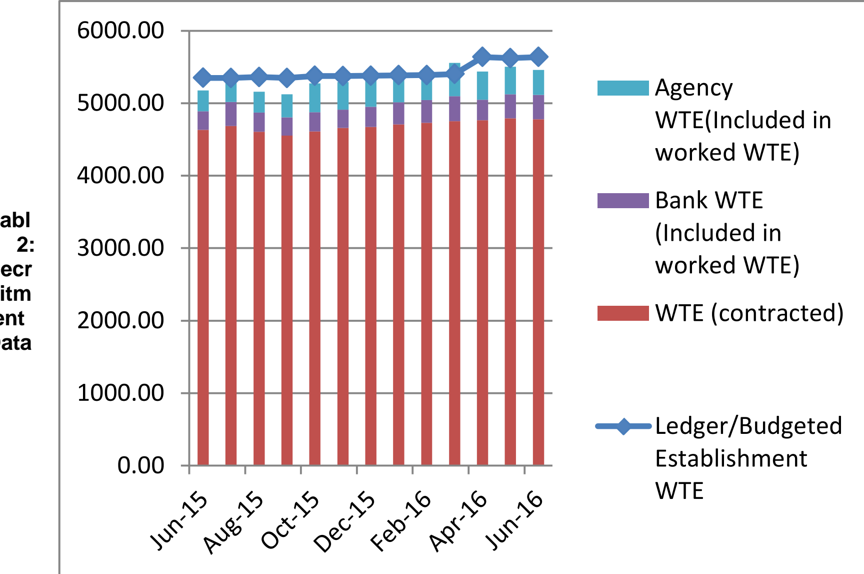


Table 2: Recruitment Data

Source: TRAC	Target	Trust June 2016 (weeks)	Trust July 2016 (weeks)	Trust August 2016 (weeks)
Time to Start: From requisition approval to start date (actual/booked)	9 weeks	8.9 weeks	8.1 weeks	9.3 weeks
Time to Recruit: From conditional offer to Start date (booked/actual)	2.6 weeks	3.1 weeks	2.8 weeks	3.5 weeks
Time taken for approvals: From requisition being created to requisitions authorised	2 weeks	0.9 weeks	0.6 weeks	1.0 week

Table 3: Establishment changes 16/17: Substantive Posts WTE

	Cancer division	Clinical Support division	Corporate division	Medical division	R&D	Surgery division	Womens & Childrens division	Grand Total
Adjustment	-0.4					-0.42		-0.42
Admin and estates	4.5	12.83	39.25	20.16	7.9	8.31	7.43	100.38
Medical and dental	-0.96	0.7	0	12.11	-1.46	0.42	3.2	14.01
Nursing qualified	-2.43	0.89	3.03	38.12	-0.43	13.57	-0.36	52.39
Nursing unqualified	1.96	0.37	-1	16.93	-1	11.38	2.42	31.06
St and T	6.71	-1.97	0	2.19	1.85	8.44	-0.92	16.3
ST and T unqualified	-1	-1.17		-1		1.32	-0.08	-1.93
Grand Total	**8.38**	**11.65**	**41.28**	**88.51**	**6.86**	**43.02**	**11.69**	**211.39**

Table 4: Establishment changes 16/17: Bank & Agency Posts WTE

	Cancer division	Clinical Support division	Corporate division	Medical division	R&D	Surgery division	Women’s & Children’s division	Grand Total
Admin and estates agency				-4.51		-4	0	-8.51
Admin and estates bank		-2.08	-2.11	0	-0.43	9.96	1.5	6.84
Agency Medical and dental						4.29		4.29
Agency nursing qualified				13.47				13.47
Bank nursing qualified	-0.51	-0.73	0	3.26	0	-0.14	5.63	7.51
Bank nursing unqualified	-0.08	0		1.2		0.44	0	1.56
St and t bank	-4	9.6		2		0		7.6
Grand Total	**-4.59**	**6.79**	**-2.11**	**15.42**	**-0.43**	**10.55**	**7.13**	**32.76**

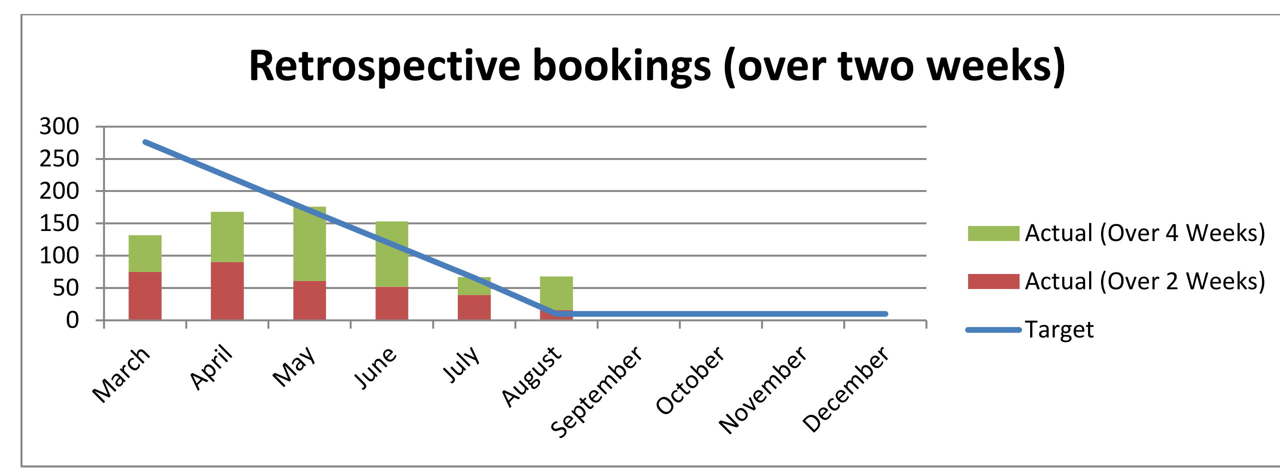
Table 5: Benchmarking Data: Beds and Herts NHS Organisations - Vacancy, Turnover and Agency costs comparisons - June 2016 (*awaiting data*)

Trust	Mandatory Training Rate June 16	Appraisal Rate June 16	Turnover June 16	Sickness June 16	Agency June 16
Bedford Hospital	76%	81%	10.90%	3.30%	6.50%
Herts Community	86%	88%	19.10%	3.70%	9.00%
WHHT	88%	88%	15.50%	2.80%	12.00%
East & North Herts	**87%**	**79%**	**12.90%**	**3.96%**	**10.50%**
Luton & Dunstable	86%	73%	15.90%	2.80%	7.60%
HPFT	88%	83%	14.10%	3.96%	6.30%
ELF Bedford	99%	99%	17.80%	4.60%	11.40%
ELF Luton	86%	80%	19.80%	3.70%	14.00%
Princess Alexandra	79%	59%	21.10%	3.50%	10.00%
SEPT		90%	16.30%	4.40%	
CNWL FT	91%	86%	13.10%	4.05%	
Average	**86%**	**82%**	**16.0%**	**3.7%**	**9.70%**

Table 6: NHSP Performance

Staff Group	Current YTD Month & Year	Net Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
Nursing & Midwifery	July 2016	10,699	4,329	40.5 %	4,375	40.9 %	81.4 %	1,995	18.6 %
	August 2016	10,864	4,082	37.6 %	3,684	33.9 %	71.5 %	3,098	28.5 %
Doctors	July 2016	2359	729	31%	827	35%	66%	803	34%
	August 2016	2494	829	33%	863	35%	68%	802	32%
Admin & Clerical	July 2016	2,483	1,486	59.8 %	836	33.7 %	93.5 %	161	6.5 %
	August 2016	2,660	1,632	61.4 %	828	31.1 %	92.5 %	200	7.5 %
Allied Health Prof, Health Care Sciences	July 2016	2,622	1,212	46.2 %	1,136	43.3 %	89.5 %	274	10.5 %
	August 2016	2,915	1,210	41.5 %	1,223	42.0 %	83.5 %	482	16.5 %

Graph 2: Retrospective Bookings



Retrospective Bookings: The graph demonstrates the planned reduction of retrospective booking based on current volumes. The plan focuses on reducing the requests that are greater than 2 weeks retrospective while ensuring the volume under 2 weeks retrospective does not increase.
** Graph represents retrospective bookings only*

Table 7: Performance, Employee Relations

Source: ERAS	Total Live Cases as at 30 June 2016	Total Live Cases as at 31 August 2016	Surgery	Medicine	CS	W & C	Cancer (inc R&D)	Corporate
Headcount	5470	5509	1311	1395	747	769	692	595
Number of Disciplinary Cases (excluding medical cases) % = no of cases as % of headcount	13 (0.2%)	12 (0.2%)	2	1	3	1	4	1
Number of Grievances	4	1	1	0	0	0	0	0
Number of Capability cases	8	8	3	3	0	0	2	0
Number of B&H, discrimination and victimisation cases	8	7	1	1	4	1	0	0
Number of formal short term sickness cases including cases under monitoring	112	54	12	16	14	6	2	4
Number of formal long term sickness cases Including cases under monitoring	67	54	13	21	6	9	2	3
Number of *MHPS cases (Medical cases)	2	2	1	0	0	1	0	0
Total number of cases in progress	214	138						
Number of suspensions/medical exclusions	4	4	2	0	0	0	2	0
Number of suspensions lasting 6 months or longer								
Number of appeals	18	3	0	0	0	0	2	1

***MHPS = Maintaining High Professional Standards**

Table 8: ERAS (Exit Interview Data) Headcount 39

Table 8: Exit Interview data demonstrates that 39 people left the Trust.
Table 8a: shows breakdown of different reasons as to people leaving the Trust.

A. Reason of Leaving	
Enhanced Job Opportunity	9
Salary	0
Lack of challenge	1
Lack of support from Mgt	2
Career Change	1
Reason Unknown	3
Relocation	6
Retirement	5
Family/Personal reasons	6
Dissatisfaction with Mgr	0
Working Conditions	1
Further Education	5

B. Length of Service within the Trust	
> 12 months	11
1-5 Years	15
6-10 Years	7
11-15 Years	1
16-20 Years	1
21-25 Years	1
26-30 Years	3

C. Band	
1	0
2	14
3	6
4	1
5	4
6	8
7	5
8	0
9	1

D. Department	
Pharmacy	1
Health Records	1
Mount Vernon Cancer Centre	7
Facilities	1
Orthopaedics	0
Obstetrics & Gynaecology	4
Elderly Care	1
Outpatients Services	2
Surgical Specialties	4
Specialty Medicine	0
Child Health	1
Quality Control	1
Anaesthetics, Theatres, Critical Care	0
Strategic Development	0
General Surgery and Urology	3
Nursing Practice	0
Cardiology	0
Acute Medicine	4
Research and Development	0
Emergency Department	0
Renal	2
Pathology	0
Radiology	5
Finance	0
Trust Management	0
Oncology & Clinical Haematology	1
Education and Training	1

Qualitative Exit Interview Data

The following summarises the responses obtained to questions asked at exit interviews for the period of August 2016, and provides some analysis of the key trends identified amongst the leavers.

What factors contributed to employees decisions to leave the Trust?

Enhanced Job opportunity

Some employees stated that they left as they wished to progress to a higher band or had an opportunity to progress on to next level of training.

Relocation

Employee took decision to leave and relocate; two reasons provided are:
- Moving back to their home town and
- Reside near their families

Retirement

People choose to retire as they were reaching retirement age.

Staff Group (Nursing & Midwifery)

- A band 6 from Obstetrics & Gynaecology left after 7 years of service because of childcare issues and was unable to have 15 hour per week contract. The employee also felt sufficient breaks were not provided.
- A band 6 from Mount Vernon Cancer Centre left after 6 years of service because of lack of support from management & poor management. The employee felt that they were being treated like child, there was no respect for each other and staff were not being listened to.

Staff Group (Allied Health Professionals)

- A band 6 from Radiology left after 8 years of service because of promotion of shift system and lack of staff. The employee felt unhappy about a shortage of staff and stress at work.
- A band 2 from General Surgery and Urology left after 4 years of service because of lack of staffing and staff being taken away. The employee stated that they had been moved to heavy wards whilst pregnant and had been put at risk. The employee preferred QE2 and did not like working at Lister.
- A band 6 from Mount Vernon Cancer Centre left after 1.5 years of service because of promotion to a more patient based role. The employee felt staff shortages and lack of support were key issues for the Trust.

Staff Group (Administrative & Clerical)

- A band 2 from Health records left after 10 years of service because of poor job prospects, lack of motivation and stress. The employee felt that PIVOTis a smoke screen of box ticking and blame shuffling.

Table 9: Independent contractors (excluding high value agency workers) April 2016 to end June 2016

Department	Duties	Contract Arrangements
Finance	Capital Projects Finance Lead	Anticipated contract end date is 30 September 2016.
Finance	Senior Contracts Manager	Contract extended to 31 October 2016.
Finance	Finance income capture/recovery project	Contract to 31 August 2016
Transformation Programme Office	Consultant	Ongoing for one day per week.
Information Management	EPR Programme Consultant	Contract to 30 November 2016
Information Management	Change Analyst for Pharmacy Stock Control	Contract to 18 November 2016
Information Management	EPR Project Manager	Contract to 30 November 2016
Information Management	Testing Services Consultant	Contact to 5 December 2016
Information Management	EPR Programme Manager	Anticipated contract end date is 1 October 2016.
Information Management	EPR Programme Consultant	Anticipated contract end date is 4 July 2016.
Operations	7 Day Working project Lead	Contract to 31 October 2016
Workforce & OD	ESR E-forms Project Consultants (2)	Both Contracts have now finished; one ended on 30 April 2016 and the other ended 30th June 2016.
Workforce & OD	Locum Consultant Physician in Occupational Health	Contract to be extended, to allow for substantive recruitment to post.
Workforce and OD	ADDS consultant	Contract to 30 September 2016.
Workforce and OD	ADDS Project Consultant	Contract ended on 30 June 2016.

TRUST - WIDE

Trust-wide	Actual					Predictions/Assumption based on pipeline and known leavers													
	16/17																		
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16/17 Total	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Overall Trust Vacancy Factor at the end of the month	9.88%	10.76%	13.32%	14.46%	13.51%	13.04%	12.03%	11.27%	10.47%	9.56%	9.25%	8.20%		7.31%	6.86%	6.80%	6.45%	6.62%	6.41%
Trust-wide vacant posts (at the end of the month)	484	527	679	744	694	670	618	579	538	491	475	421		375	352	349	331	340	329
Trust-wide vacant posts (at the beginning of the month, incl. any funded establishment changes)	503	484	527	679	744	694	651	623	584	543	496	480		414	380	357	354	336	345
Number of starters required to achieve target	78	78	78	78	78	78	78	78	78	78	78	78		78	78	78	78	78	78
Estimated starters in month *	75	67	70	47	72	81	90	101	103	109	78	116		96	85	65	80	53	73
Actual starters in month*	81	55	78	56	92	0	0	0	0	0	0	0		0	0	0	0	0	0
Variance	-6	12	-8	-9	-20	TBC	TBC	TBC	TBC	TBC	TBC	TBC	-31	TBC	TBC	TBC	TBC	TBC	TBC
Estimated leavers in month*	43	41	36	36	36	57	57	57	57	57	57	57		57	57	57	57	57	57
Actual leavers in month*	49	48	59	65	67	0	0	0	0	0	0	0		0	0	0	0	0	0
Variance	-6	-7	-23	-29	-31	TBC	TBC	TBC	TBC	TBC	TBC	TBC	-96	TBC	TBC	TBC	TBC	TBC	TBC

BAND 5 REGISTERED NURSES

Band 5	16/17																		
Month	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16/17 Total	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Vacancies b/fwd (incl. any changes in funded establishment)	181	179	218	220	234	240	230	211	196	179	151	134		99	64	60	56	57	65
Monthly starters																			
Estimated UK	9	4	5	8	8	8	9	9	9	15	15	15		15	15	15	8	8	8
Estimated EU	7	3				5		3	2	3									
Estimated Filipino Nurses Cohort 1	6	9	2	3	3	1			3	2	2	8		10					
Estimated Filipino Nurses Cohort 2					3	1		4	2	6	4	23		21					
Estimated Additional Filipino Recruits			11	2	3	1		5	17	18	1								
Estimated Newly Qualified Nurses						10	26	10											
Estimated Other Overseas Nurses											11	5		5	5	5	7		
Actual UK	3	2	5	5	9														
Actual EU	2	1																	
Actual Filipino Nurses Cohort 1	4		2	3	1														
Actual Filipino Nurses Cohort 2	1																		
Actual Additional Filipino Recruits			11	2															
Actual Newly Qualified Nurses																			
Actual Other Overseas Nurses																			
Starters Variance	12	13	0	3	7	TBC	TBC	TBC	TBC	TBC	TBC	TBC	35	TBC	TBC	TBC	TBC	TBC	TBC
Attrition Mthly																			
Estimated	10	9	9	9	9	11	11	11	11	11	11	11		11	11	11	11	11	11
Actual	7	10	10	14	9														
Esitmated Internal promotion for band 5	5	5	5	5	5	5	5	5	5	5	5	5		5	5	5	5	5	5
Actual Internal promotion for band 5	1	4	4	4	2														
Attrition Variance	7	0	0	-4	3	TBC	TBC	TBC	TBC	TBC	TBC	TBC		TBC	TBC	TBC	TBC	TBC	TBC
Estimated Vacancies (+) c/fwd	174	177	214	221	231	230	211	196	179	151	134	99		64	60	56	57	65	73
Actual Vacancies (+) c/fwd	179	190	214	228	235														
Estimated Vacancy rate	19.05%	19.38%	22.76%	23.48%	24.36%	24.29%	22.28%	20.70%	18.91%	15.95%	14.16%	10.47%		6.77%	6.35%	5.93%	6.03%	6.88%	7.72%
Actual Vacancy Rate	19.60%	20.80%	22.76%	24.23%	24.78%	TBC	TBC	TBC	TBC	TBC	TBC	TBC		TBC	TBC	TBC	TBC	TBC	TBC

BAND 2 CSWs

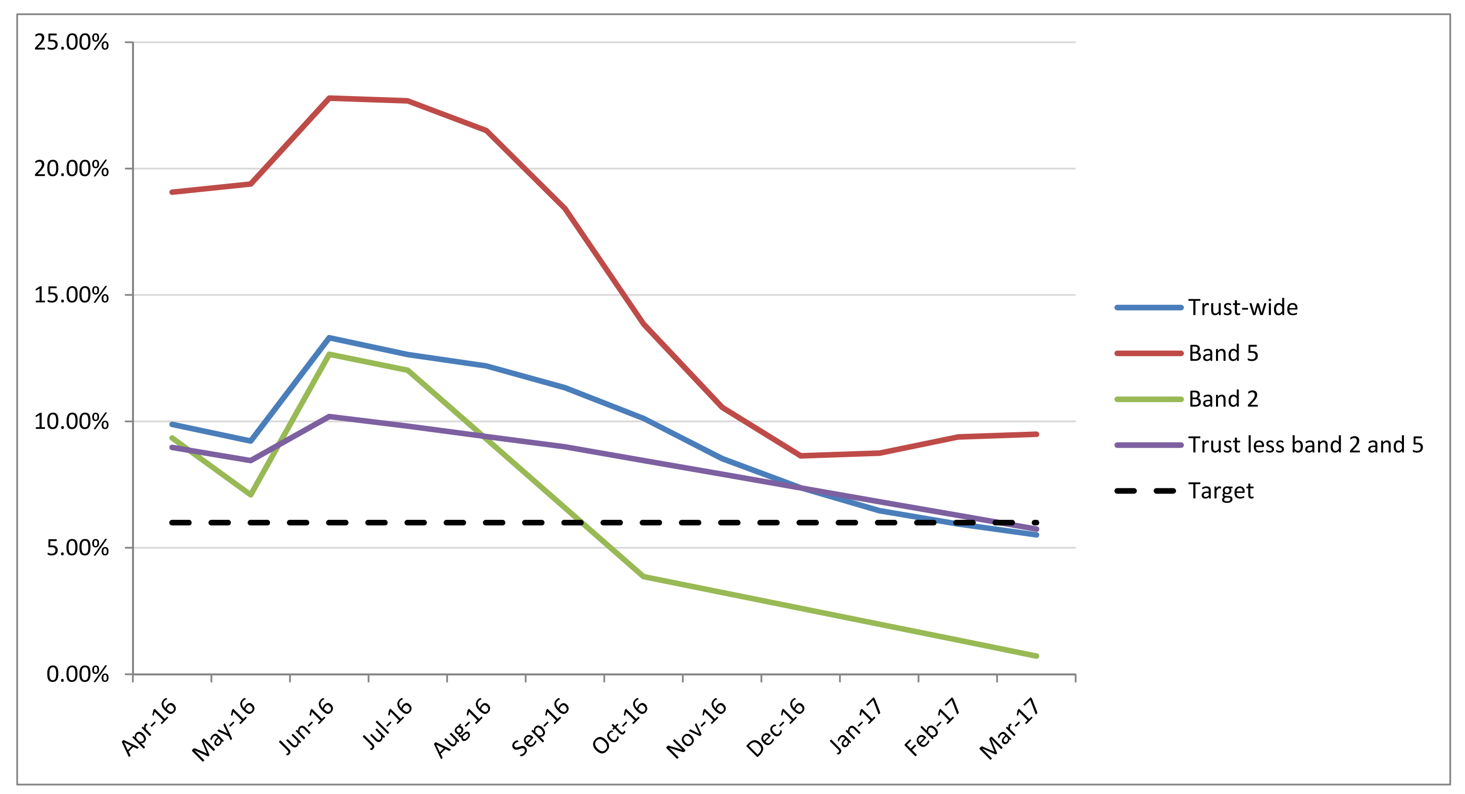
Band 2	16/17																		
Month	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16/17 Total	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Vacancies b/fwd (incl. any changes in funded establishment)	**52**	**41**	**73**	**61**	**72**	**66**	**64**	**62**	**45**	**28**	**16**	**24**		**0**	**8**	**-4**	**4**	**-8**	**0**
Monthly starters																			
Estimated	18	16	20	0	20	10	10	25	25	20	0	20		0	20	0	20	0	20
Actual	17	10	26	3	13														
Starters Variance	**1**	**6**	**-6**	**-3**	**7**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**		**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**
Attrition Mthly																			
Estimated	8	7	7	7	7	8	8	8	8	8	8	8		8	8	8	8	8	8
Actual	6	8	10	7	11														
Attrition Variance	**2**	**-1**	**-3**	**0**	**-4**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**
Estimated Vacancies (+) c/fwd	**42**	**32**	**60**	**68**	**59**	**64**	**62**	**45**	**28**	**16**	**24**	**12**		**8**	**-4**	**4**	**-8**	**0**	**-12**
Actual Vacancies (+) c/fwd	**41**	**39**	**57**	**65**	**70**														
Estimated Vacancy rate	9.41%	7.17%	12.64%	14.41%	12.65%	13.56%	13.13%	9.51%	5.90%	3.34%	5.05%	2.49%		1.70%	-0.85%	0.85%	-1.70%	0.00%	-2.55%
Actual Vacancy Rate	9.19%	8.74%	12.01%	13.78%	14.99%	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**		**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**

TRUST - WIDE (EXCL. BAND 2 AND BAND 5)

Trust-wide (except band 2 and band 5)	16/17																		
Month	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16/17 Total	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Vacancies b/fwd	**328**	**310**	**388**	**393**	**379**	**364**	**357**	**350**	**343**	**336**	**329**	**322**		**315**	**308**	**301**	**294**	**287**	**280**
Monthly starters																			
Estimated *	35	35	32	34	35	45	45	45	45	45	45	45		45	45	45	45	45	45
Actual *	54	42	34	43	69														
Starters Variance	**-19**	**-7**	**-2**	**-9**	**-34**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**
Attrition Mthly																			
Estimated *	25	25	20	20	20	38	38	38	38	38	38	38		38	38	38	38	38	38
Actual*	36	30	39	44	47														
Attrition Variance	**-11**	**-5**	**-19**	**-24**	**-27**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**
Estimated Vacancies (+) c/fwd	**318**	**300**	**376**	**379**	**364**	**357**	**350**	**343**	**336**	**329**	**322**	**315**		**308**	**301**	**294**	**287**	**280**	**273**
Actual Vacancies (+) c/fwd	**310**	**298**	**393**	**394**	**357**														
Estimated Vacancy rate	8.98%	8.47%	10.20%	10.16%	9.79%	9.60%	9.41%	9.23%	9.04%	8.85%	8.66%	8.47%		8.28%	8.10%	7.91%	7.72%	7.53%	7.34%
Actual Vacancy rate	8.76%	8.42%	10.67%	10.56%	9.60%	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**		**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**

*(excludes doctors in training)

Month	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Trust-wide	9.89%	9.23%	13.31%	12.65%	12.20%	11.33%	10.12%	8.53%	7.37%	6.47%	5.94%	5.51%
Band 5	19.07%	19.39%	22.78%	22.68%	21.51%	18.42%	13.85%	10.55%	8.64%	8.75%	9.38%	9.49%
Band 2	9.35%	7.10%	12.66%	12.03%	9.31%	6.59%	3.86%	3.24%	2.61%	1.98%	1.35%	0.72%
Trust less band 2 and 5	8.97%	8.46%	10.19%	9.81%	9.41%	9.00%	8.46%	7.91%	7.37%	6.83%	6.29%	5.74%
Target	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%



RISK AND QUALITY REPORTS

Safe Staffing Nursing
Infection Control

Safe Nurse Staffing Levels

July 2016

Executive Summary

The purpose of this report is:

1. To provide an assurance with regard to the management of safe nursing and midwifery staffing for the month of July 2016.
2. To provide context for the Trust Board on the UNIFY safer staffing submission for the month of July 2016.

East and North Hertfordshire NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives and Clinical Support Workers (CSWs), match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care. These staffing levels are viewed along with reported outcome measures, 'registered nurse to patient ratios', the percentage skill mix ratio of registered nurses to CSWs, and the number of staff per shift required to provide safe and effective patient care.

No	Topic	Measure	Summary	RAG
1.	**Patient safety is delivered though consistent, appropriate staffing levels for the service.**	Unify RN fill rate	Fill rate of 95.% for registered nurses for July	
		Care hours per Patient Day - CHPPD	Overall CHPPD is 7.7. This is the second month of reporting so no comparable data until July 2016	
2.	**Staff are supported in their decision making by effective reporting.**	% of Red triggered shifts	Increase in red triggered shifts to 4.42%	
		% of shifts that remained partially mitigated	7 shifts ie 0.20% out of all shifts in month. This is a reduction since June. These consisted predominantly of Late shifts	
3.	**Staffing risks are effectively escalated to an appropriate person**	Red flag reportable events and DATIX report	July demonstrated an increase in red flags raised. This correlates with the reduction in red triggered shifts	
4.	**The board are assured of safe staffing for nursing across the organisation**	The board are not sited on nurse staffing issues across the organisation.	The overall RN fill rate decreased in July and the subsequent number of unfilled shifts increased for the month. This is in part due to continued demand to cover short notice sickness on wards, a drop in temporary staffing fill, increase in annual leave and use of surge capacity areas to support increasing demand.	

1. Patient safety is delivered though consistent, appropriate staffing levels for the service.

The following sections identify the process in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

1.1 UNIFY Safer Staffing Return

The Trust's safer staffing submission has been submitted to UNIFY for July: Table 1 below shows the summary of overall fill %; the full table of fill % can be seen in Appendix 1:

Table 1 – Overall Unify Return fill rate

Day		Night	
Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)
95.9%	112.3%	99.6%	116.4%

The July Unify submission for registered fill % fell compared to June with the average day fill % for registered nurses falling to 95.9% from 97.5%. The decrease in fill for all care staff is due to annual leave being towards the upper end of the threshold for the month for our substantive workforce, while we have had a decrease in temporary staffing fill from 16% in June to 16.6% unfilled for July. Overall temporary staffing fill can be seen in Appendix 2.

1.2 Factors affecting Planned vs Actual staffing

There are a number of other contributory factors which affect the fill rate for July. This, along with the summary of key findings by ward, can be seen below:

- **Escalation areas** – ACU has 4 escalation beds that are opened to enable the Trust to manage surges in activity. This proactive opening does not form part of the unit's planned hours. The overall RN fill rate on ACU was 114.1% of their planned hours. ACU the Discharge Lounge, Cardiac Catheter Lab and Ambulatory Care at Lister were all opened to inpatients as required to support the additional activity.
- **Matrons and Specialist Nurses** - Matrons and Specialist Nurses worked clinically to support wards where staffing fell below the minimum safe levels.
- **Ward 10 & Ward 11** – The establishment review for Wards 10 and 11 have now been completed, which will reduce the need to 'share staff, however the flexible nature of these services does mean units flex down staffing levels as required.
- **10B, 11A, 11B, 6A, 9A, 9B, 5A, Ashwell, AMU-W, Barley, Pirton and SSU** – Had a high number of patients requiring enhanced care which resulted in increased CSW fill.

The introduction of the Enhanced Dementia support Team (specialing team) at the beginning of January has helped to mitigate this risk and reduce the need to cover this with temporary staffing, in addition to providing enhanced support to those patients needing specialing. Demands for specilling are increasing. **Table 2** outlines the reduction in costs compared to April 2014 and April 2015. The team are currently recruiting to establishment and a detailed evaluation of the impact of the EDST team will be carried out in September 2016.

Table 2

Month/ Year	Costs
April 2014	128,000
April 2015	114,000
April 2016	88,000

1.3 UNIFY Care Hours Per Patient Day (CHPPD)

From 1 May 2016 each Trust is required to report the number of Care Hours per Patient Day (CHPPD). This figure is calculated:

The total number of patient days over the month
(Sum of actual number of patients on the ward at 23:59 each day)
/
Total hours worked in month
(Total hours worked for registered staff, care staff and then combined)

This is a standard calculation indicating the number of care hours provided to each patient over a 24 hour period. As this is the first month collecting this data we have no trend information available, over time this information will be used to add intelligence on how wards are staffed.

The table below shows the CHPPD for July, this indicates there was a slight decrease in overall CHPPD from 8.0 in June to 7.7 in July.

Table 3 – Average Care Hours Per Patient Day

Trustwide	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
Total	5.0	2.6	7.7

CHPPD is included in our bi-annual establishment reviews and the results seen on the Unify return do fall within expected thresholds when compared to this data. A full list of CHPPD by ward can be seen in Appendix 4.

2. Staff are supported in their decision making by effective reporting

2.1 Daily process to support operational staffing

The daily and twice weekly look ahead meetings continue to support the organisation in balancing staffing risk across the Trust. Each ward is rated as red, amber or green for each of the early, late and night shifts. This record is held electronically and kept live in the Operations Centre and provides assurance on nurse staffing levels in the organisation.

2.2 Staffing levels and shifts that trigger red

In July the number of shifts initially triggering red decreased to 124 out of 3441 shifts compared to 245 shifts in June (see Table 3 below).

Table 4 – % of shifts triggering red

Month	% of shifts that triggered red in Month
Jul-15	2.67%
Aug-15	4.89%
Sep-15	4.24%
Oct-15	5.47%
*Nov 2015	3.00%
Dec-15	3.16%
Jan-16	4.13%
*Feb 2016	7.10%
Mar-16	8.60%
*Apr 2016	7.36%
May-16	3.60%
Jun-16	5.44%
Jul-16	4.42%

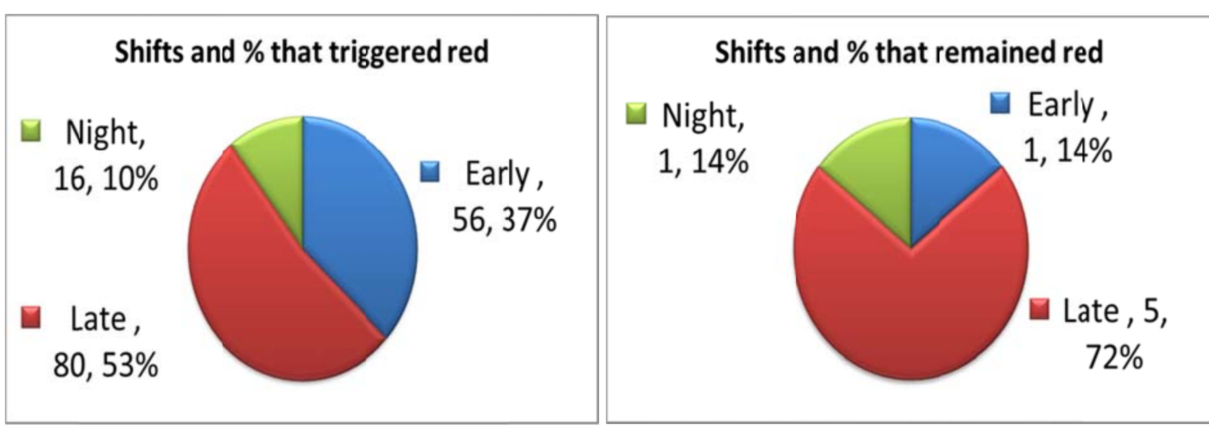
* Indicates where agency cap was implemented in November 2015, February and April 2016.

Comparison of red triggered shifts between July 2015 and July 2016 demonstrate an increase in the number of shifts triggering red in month.

Out of the shifts triggering red, 7 of the 152 initially triggered reds (0.2%) shifts remained partially mitigated; this is a decrease from 20 shifts in June. Shifts triggering red, and those that remained a challenge to mitigate, are explored below.

Chart 1 below shows the number and % distribution of red triggered shifts and those shifts that remained red after mitigating action was taken. This indicates that the majority of the red shifts triggered remain on the late shift.

Chart 1 – Shifts initially triggering red & remained red



A full list of all the wards with triggering red shifts can be found in Appendix 3. This shows a decrease in distribution of wards triggering red. Three wards triggered red on 10% or more of the shifts in month which is a decrease from 14 wards in April. Red shifts have been mitigated by moving staff between wards to balance staff numbers and skill; this also mitigates the use of agency staff.

Table 5 below shows the shift breakdown for each of these wards.

Table 5 – Wards triggering high number of red shifts

		INITIAL REDS				
Ward	**Total no. of shifts available**	**Early**	**Late**	**Night**	**Number of shifts where staffing initially fell below agreed levels**	**% of shifts where staffing fell below agreed levels and triggered a Red rating**
Pirton	93	5	9	0	14	15.05
A&E	93	4	7	0	11	11.83
Bluebell	93	6	7	1	14	15.05

2.3 Summary of factors affecting red triggering shifts

There are several key factors that have impacted the incidence of red shifts, these include:

- Temporary Staffing Fill – An increase in overall fill rate from 85.0% to 81.2% from NHSP, resulted in an increased number of shifts triggering red and remaining a challenge to mitigate. This overall reduction is further seen by the smaller distribution of red triggering shifts across the wards.
- Vacancy Rate – Nurse vacancy rate at ward level remains consistent (17.29%) and continues to impact temporary staffing requirement.
- Sickness – Sickness rate remains above the 4% budget position, with July sickness recorded at 6.5% (taken from e-roster)for the inpatient wards.
- Enhanced Care requirements
- Opening of surge capacity areas has increased temporary staffing demand

3 Staffing risks are effectively escalated to an appropriate person

Each morning shifts that fall below minimum staffing levels are escalated to the divisional staffing bleep holder who moves to balance risk across the division. Where the division are unable to mitigate themselves this is escalated to the Nursing Service Manager to balance risk across the organisation.

3.1 Red Flags

Red flags are NICE recommended nationally reportable events that require an immediate response from the Senior Nurse Team. “Red flag events” signal to the Senior Nurse Team an urgent need for review of the numbers of staff, skill mix and patient acuity and numbers. These “red flag events” include patients not being provided with basic care requirements, such as help with visits to the bathroom, being asked about pain levels or delays in providing medicines. The Senior Nurse team considers any “red flag events” as indicators of the ward requiring an intervention e.g increasing staffing levels, facilitating patient discharge or closing to admissions for a temporary period following discussion and agreement with the Operations Centre and the Executive on call.

Chart 2 below shows the type and number of red flags raised for the reason shortfall in RN time in July. The chart shows the highest number of red flags relate to shortfall in RN time. This is a decrease from the 34 'Shortfall in RN time' red flags for June. As red flags have started to embed in the organisation we are starting to see the data match other indicators, for example staffing the late shift is when most staffing shortages are escalated, this is supported by the red triggering shift data.

Chart 2 – Red Flags by type

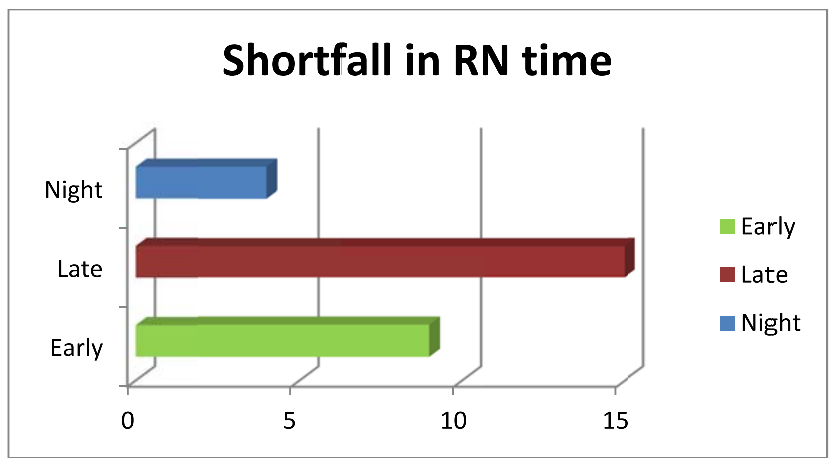
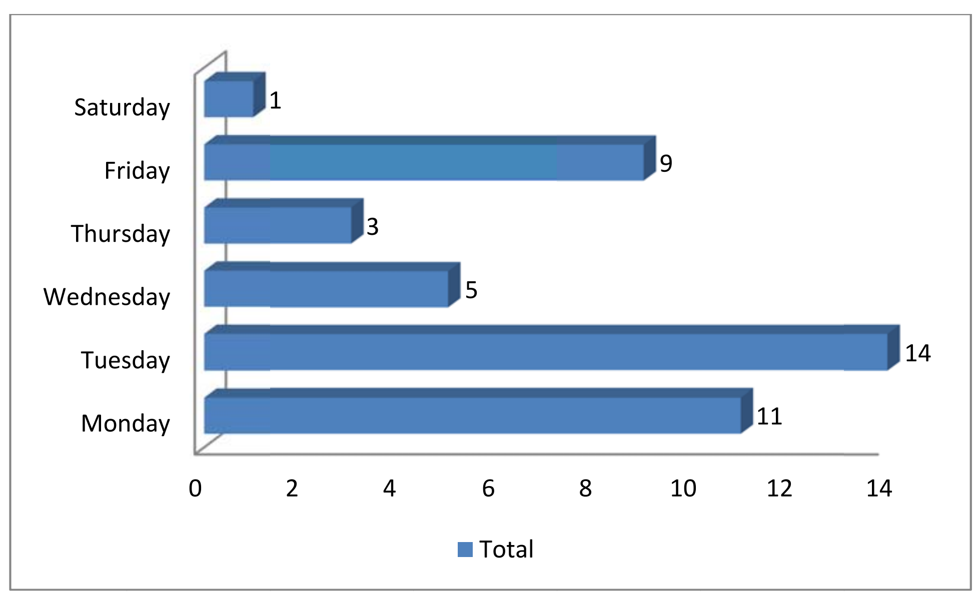


Chart 3 below indicates the red flags by day of the week; this shows that Monday, Tuesday and Friday are the days where staffing is most likely to be escalated.

Chart 3 Red Flags Day/Night



4. The Board are assured of safe staffing for nursing across the organisation

The overall RN fill rate decreased in July and the subsequent number of unfilled shifts increased for the month. This is in part due to continued demand to cover higher than budgeted short notice sickness on the inpatient areas, drop in temporary staffing fill, increase in annual leave and the sustained use of surge capacity areas to support increasing demand. The maintenance of safe staffing levels on wards in July was supported by:

- Continued daily monitoring and ward RAG rating of staffing levels across inpatient wards
- Red Flags used to effectively escalate nationally reportable events to allow appropriate immediate action to be taken.
- Working with cap compliant agencies
- Working with agencies to identify long line agencies to support areas with high vacancies
- Challenge and confirm culture for all additional duties being added to roster
- Controlled release of unfilled shifts to agencies
- Improved reporting and monitoring through SafeCare and Red Flag process
- Additional support provided by e-Roster, NHSP and Temporary Staffing management to assist wards with staffing challenges
- Active management and support to review staffing requirements on a daily basis for identified wards
- NSMs, Matrons, specialist nurses and the education team have supported clinically where needed.

In addition the Director of Nursing is working with a national safer staffing group reviewing the guidance.

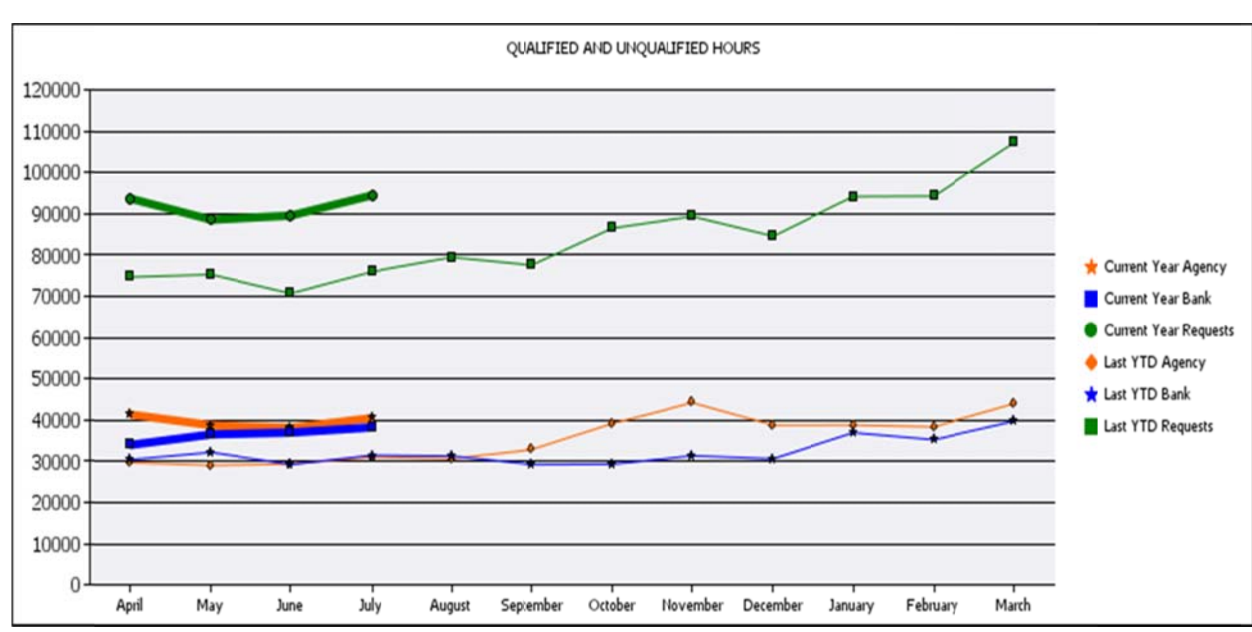
The Board are asked to note the data and supporting processes identified in this report which provide assurance of safe staffing levels in the Trust and the impact on patient safety.

Appendix 1

Ward name	Day		Night	
	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)
10B	96.7%	139.5%	100.3%	147.8%
11A	97.7%	103.2%	101.6%	165.1%
11B	96.7%	123.4%	103.0%	100.3%
5A	92.6%	105.3%	100.3%	134.1%
5B	96.6%	94.9%	100.0%	93.2%
6A	96.3%	139.7%	100.7%	116.5%
6B	94.5%	87.6%	101.4%	100.8%
7A Gynae	94.3%	125.3%	99.6%	115.9%
7B	95.0%	94.8%	96.4%	109.3%
7AN	80.3%	145.7%	101.3%	97.3%
8A	98.8%	94.3%	97.7%	100.2%
8B	95.8%	91.8%	101.9%	100.6%
9A	98.5%	133.4%	101.3%	165.8%
9B	101.9%	121.0%	100.7%	146.9%
ACU	99.3%	101.4%	114.2%	128.8%
AMU-A	95.2%	97.8%	87.0%	103.7%
AMU-W	95.3%	136.4%	99.4%	124.7%
Ashwell	97.0%	153.9%	108.3%	118.9%
Barley	93.2%	129.8%	101.2%	134.6%
Bluebell	89.3%	171.5%	93.0%	#DIV/0!
Critical Care 1	100.0%	100.0%	100.0%	100.0%
Dacre	97.8%	#DIV/0!	93.5%	#DIV/0!
Gloucester	99.1%	97.8%	102.8%	90.5%
CLU	101.9%	100.9%	101.3%	85.7%
Mat MLU	97.4%	96.1%	97.8%	113.4%
Michael Sobell House	99.2%	121.3%	99.0%	98.8%
Pirton	83.9%	111.6%	100.8%	106.5%
SAU	84.0%	104.0%	99.1%	136.3%
SSU	100.4%	105.0%	96.0%	125.3%
Swift	89.4%	91.9%	97.8%	97.4%
Ward 10	84.0%	109.3%	90.8%	#DIV/0!
Ward 11	97.6%	80.1%	86.7%	#DIV/0!
Total	**95.9%**	**112.5%**	**99.6%**	**116.4%**

Appendix 2

NHSP hours YTD report



Appendix 3

Shifts that initially triggered red in July 2016

Speciality	Ward	INITIAL REDS					
		Total no. of shifts available	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a Red rating
Care of the Elderly	9A	93	1	1	0	2	2.15
	9B	93	0	2	1	3	3.23
Stroke	Barley	93	4	1	0	5	5.38
	Pirton	93	5	9	0	14	15.05
General	6A	93	0	1	0	1	1.08
	10B	93	3	6	0	9	9.68
Respiratory	11A	93	1	4	0	5	5.38
	Escalation Ward	93	1	4	0	5	5.38
Cardiology	ACU	93	0	4	1	5	5.38
Acute	AMU-A	93	0	2	0	2	2.15
	SSU	93	1	2	0	3	3.23
	AMU-W	93	1	2	0	3	3.23
Renal	6B	93	4	5	0	9	9.68
DTOC / gastro	Ashwell	93	6	2	0	8	8.60
ED	A&E	93	4	7	0	11	11.83
	UCC	93	0	0	1	1	1.08
		1488	**31**	**52**	**3**	**86**	**5.78**
General	8A	93	2	0	1	3	3.23
	8B	93	2	3	1	6	6.45
	SAU	93	0	0	0	0	0.00
Surgical Spec	11B	93	1	2	1	4	4.30
	7B	93	2	0	0	2	2.15
T&O	5A	93	2	1	0	3	3.23
	5B	93	4	2	0	6	6.45
	TC Swift	93	1	2	1	4	4.30
ATCC	Critical Care 1	93	0	0	2	2	2.15
	ASCU	93	0	0	0	0	0.00
		930	**14**	**10**	**6**	**30**	**3.23**
Gynae	7A Gynae	93	1	3	0	4	4.30
Paeds	Bluebell	93	6	7	1	14	15.05
	Child A&E	93	1	1	6	8	8.60
	NICU	93	0	0	0	0	0.00
Maternity	Dacre	93	0	1	0	1	1.08
	Gloucester	93	1	3	0	4	4.30
	Mat MLU	93	0	1	0	1	1.08
	Mat CLU 1	93	0	0	0	0	0.00
		744	**9**	**16**	**7**	**32**	**4.30**
Inpatient	Ward 10	93	2	2	0	4	4.30
	Ward 11	93	0	0	0	0	0.00
	Michael Sobell House	93	0	0	0	0	0.00
		279	**2**	**2**	**0**	**4**	**1.43**
	TRUST TOTAL	**3441**	**56**	**80**	**16**	**152**	**4.42**

Appendix 4

Ward name	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
10B	3.28	2.84	6.12
11A	4.67	1.59	6.26
11B	4.13	2.89	7.02
5A	3.61	1.91	5.52
5B	3.73	2.32	6.06
6A	3.21	2.49	5.70
6B	4.46	2.89	7.35
7A Gynae	4.21	3.20	7.42
7B	3.53	1.74	5.27
7AN	3.85	2.11	5.95
8A	3.41	2.06	5.47
8B	3.96	1.77	5.73
9A	3.22	3.05	6.27
9B	3.49	2.93	6.43
ACU	5.53	2.75	8.28
AMU-A	8.17	4.95	13.12
AMU-W	4.97	4.60	9.57
Ashwell	3.20	2.93	6.14
Barley	3.98	3.21	7.19
Bluebell	7.36	1.38	8.74
Critical Care 1	23.50	2.00	25.50
Dacre	5.87	0.77	6.64
Gloucester	3.47	2.99	6.46
CLU	27.14	5.68	32.83
Mat MLU	4.81	1.42	6.24
Michael Sobell House	5.41	3.67	9.08
Pirton	4.83	2.92	7.75
SAU	5.63	3.00	8.63
SSU	3.87	2.61	6.48
Swift	3.85	2.59	6.44
Ward 10	6.28	2.43	8.71
Ward 11	8.31	2.24	10.55
Total	**5.0**	**2.6**	**7.7**

Safe Nurse Staffing Levels

August 2016

Executive Summary

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1. To provide an assurance with regard to the management of safe nursing and midwifery staffing for the month of August 2016.
2. To provide context for the Trust Board on the UNIFY safer staffing submission for the month of August 2016.

East and North Hertfordshire NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives and Clinical Support Workers (CSWs), match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care. These staffing levels are viewed along with reported outcome measures, 'registered nurse to patient ratios', the percentage skill mix ratio of registered nurses to CSWs, and the number of staff per shift required to provide safe and effective patient care.

No	Topic	Measure	Summary	RAG
1.	**Patient safety is delivered though consistent, appropriate staffing levels for the service.**	Unify RN fill rate	Fill rate of 91.3% for registered nurses for August	
		Care hours per Patient Day - CHPPD	Overall CHPPD is 7.5 down from 7.7 in July.	
2.	**Staff are supported in their decision making by effective reporting.**	% of Red triggered shifts	Highest recorded level since March 2016 at 8.57%	
		% of shifts that remained partially mitigated	25 shifts ie 0.73% out of all shifts in month. This is an increase from July. These consisted predominantly of Late shifts	
3.	**Staffing risks are effectively escalated to an appropriate person**	Red flag reportable events and DATIX report	There was an increase in august in the number of red flags raised . This correlates with the increase in red triggered shifts	
4.	**The Board are assured of safe staffing for nursing across the organisation**	The Board are not sited on nurse staffing issues across the organisation.	The overall RN fill rate decreased and the subsequent number of unfilled shifts increased for the month. This is in part due to short notice sickness on wards, drop in temporary staffing fill, increase in annual leave and the sustained use of surge capacity areas to support increasing demand	

1. Patient safety is delivered though consistent, appropriate staffing levels for the service.

The following sections identify the process in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

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Day		Night	
Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)
91.3%	107.5%	95.9%	111.6%

The August Unify submission for registered fill % fell compared to July with the average day fill % for registered nurses falling to 91.3% from 95.9%. The decrease in fill for all care staff is due to short term sickness, annual leave being towards the upper end of threshold and an increase in unfilled temporary staffing shifts from 18.8% in July to 28.6% in August.

1.2 Factors affecting Planned vs Actual staffing

There are a number of other contributory factors which affect the fill rate for August. This, along with the summary of key findings by ward, can be seen below:

- **Escalation areas** – ACU has 4 escalation beds that are opened to enable the Trust to manage surges in activity. This proactive opening does not form part of the unit's planned hours. The overall RN fill rate on ACU was 101.3% of their planned hours. ACU the Discharge Lounge, Cardiac Catheter Lab and Ambulatory Care at Lister were all opened to inpatients as required to support the additional activity.
- **Matrons and Specialist Nurses** - Matrons and Specialist nurses worked clinically to support wards where staffing fell below the minimum safe levels.
- **Ward 10 & Ward 11** – The establishment review for Wards 10 and 11 have now been completed, which will reduce the need to 'share staff, however the flexible nature of these services does mean units flex down staffing levels as required.
- **10B, 11A, 11B, 6A, 9A, 9B, 7AN, 5A, Ashwell, AMU-W and SSU** – Had a high number of patients requiring enhanced care which resulted in increased CSW fill.

The introduction of the Enhanced Dementia Support Team (specialing team) at the beginning of January has helped to mitigate this risk and reduce the need to cover this with temporary staffing, in addition to providing enhanced support to those patients needing specialing. Demands for special ling are increasing. **Table 2** outlines the reduction in costs compared to April 2014 and April 2015. The team are currently recruiting to establishment and a detailed evaluation of the impact of the EDST team will be carried out in September 2016.

Table 2

Month/ Year	Costs
April 2014	128,000
April 2015	114,000
April 2016	88,000

1.3 UNIFY Care Hours Per Patient Day (CHPPD)

From 1 May 2016 each Trust is required to report the number of Care Hours per Patient Day (CHPPD). This figure is calculated:

The total number of patient days over the month
(Sum of actual number of patients on the ward at 23:59 each day)
/
Total hours worked in month
(Total hours worked for registered staff, care staff and then combined)

This is a standard calculation indicating the number of care hours provided to each patient over a 24 hour period. The table below shows the CHPPD for August, this indicates there was a decrease in overall CHPPD from 7.7 in July to 7.5 in August.

Table 3 – Average Care Hours Per Patient Day

Trust-wide	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
Total	**4.9**	**2.6**	**7.5**

CHPPD is included in the bi-annual establishment reviews and the results seen on the Unify return do fall within expected thresholds when compared to this data. A full list of CHPPD by ward can be seen in Appendix 4 of this report.

2. Staff are supported in their decision making by effective reporting

2.1 Daily process to support operational staffing

The daily and twice weekly look ahead meetings continue to support the organisation in balancing staffing risk across the Trust. Each ward is rated as red, amber or green for each of the early, late and night shifts. This record is held electronically and kept live in the Operations Centre and provides assurance on nurse staffing levels in the organisation.

2.2 Staffing levels and shifts that trigger red

In August the number of shifts initially triggering red increased to 295 shifts compared to 124 shifts in July. (see Table 4 below).

Table 4 – % of shifts triggering red

Month	% of shifts that triggered red in Month
Aug-15	4.89%
Sep-15	4.24%
Oct-15	5.47%
*Nov 2015	3.00%
Dec-15	3.16%
Jan-16	4.13%
*Feb 2016	7.10%
Mar-16	8.60%
*Apr 2016	7.36%
May-16	3.60%
Jun-16	5.44%
Jul-16	4.42%
Aug-16	8.57%

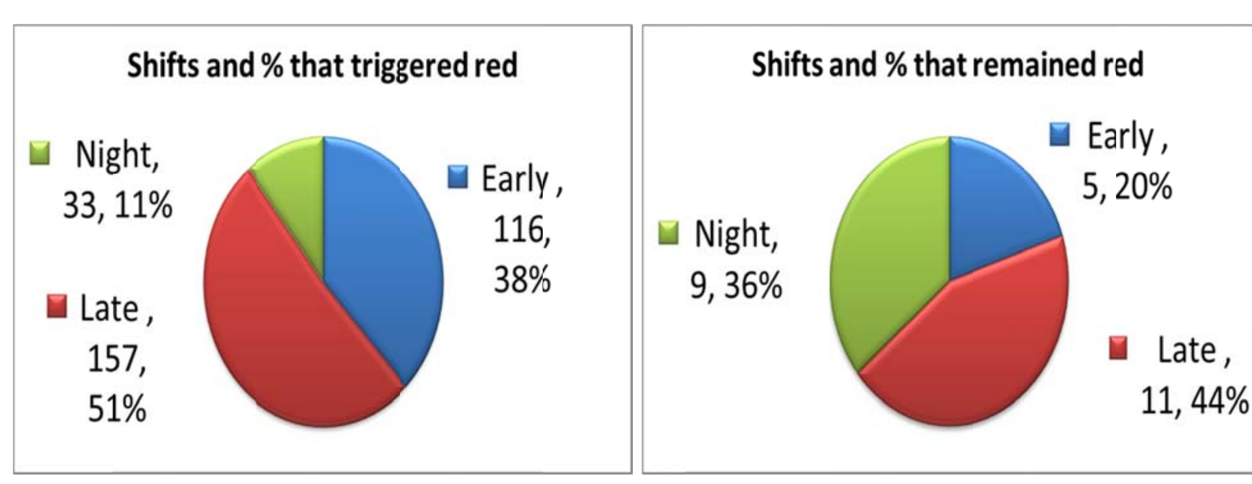
* Indicates where agency cap was implemented in November 2015, February and April 2016.

Comparison of red triggered shifts between August 2015 and August 2016 demonstrates an increase in the number of shifts triggering red in month.

Out of the shifts triggering red, 25 of the 295 initially triggered reds (0.73%) shifts remained partially mitigated; this is an increase from 7 shifts in July. Shifts triggering red, and those that remained a challenge to mitigate, are explored below.

Chart 1 below shows the number and % distribution of red triggered shifts and those shifts that remained red after mitigating action was taken. This indicates that the majority of the red shifts triggered remain on the late shift.

Chart 1 – Shifts initially triggering red & remained red



A full list of all the wards with triggering red shifts can be found in Appendix 3. 14 wards triggered red on 10% or more of the shifts in month which is an increase from 3 wards in July. Red shifts have been mitigated by moving staff between wards to balance staff numbers and skill mix.

Table 5 below shows the shift breakdown for each of these wards.

Table 5 – Wards triggering high number of red shifts

		INITIAL REDS				
Ward	**Total no. of shifts available**	**Early**	**Late**	**Night**	**Number of shifts where staffing initially fell below agreed levels**	**% of shifts where staffing fell below agreed levels and triggered a Red rating**
9B	93	9	6	1	16	17.20
Pirton	93	4	8	1	13	13.98
6A	93	6	8	0	14	15.05
10B	93	6	4	3	13	13.98
Escalation Ward	93	6	9	2	17	18.28
SSU	93	8	9	2	19	20.43
AMU-W	93	5	6	0	11	11.83
6B	93	4	5	2	11	11.83
A&E	93	4	12	3	19	20.43
	1488	**60**	**87**	**16**	**163**	**10.95**
8B	93	9	11	1	21	22.58
7B	93	6	6	0	12	12.90
5B	93	7	10	2	19	20.43
Ward 10	93	7	9	2	18	19.35
Ward 11	93	5	7	1	13	13.98
	279	**13**	**16**	**5**	**34**	**12.19**

2.3 Summary of factors affecting red triggering shifts

There are several key factors that have impacted the incidence of red shifts, these include:

- Temporary Staffing Fill – An increase in overall unfill rate from 16.6% to 28.6% from NHSP, resulted in an increased number of shifts triggering red and remaining a challenge to mitigate. This overall reduction is further seen by the smaller distribution of red triggering shifts across the wards.
- Vacancy Rate – Nurse vacancy rate at ward level remains at 17.63% and continues to impact temporary staffing requirement.
- Sickness – Sickness rate remains above the 4% budget position, with August sickness recorded at 7.5% (taken from e-roster) for the inpatient wards.
- Specialing requirements
- Opening of surge capacity areas has increased temporary staffing demand

3 Staffing risks are effectively escalated to an appropriate person

Each morning shifts that fall below minimum staffing levels are escalated to the divisional staffing bleep holder who moves to balance risk across the division. Where the division are unable to mitigate themselves this is escalated to the Nursing Service Manager to balance risk across the organisation.

3.1 Red Flags

Red flags are NICE recommended nationally reportable events that require an immediate response from the Senior Nurse Team. "Red flag events" signal to the Senior Nurse Team an

urgent need for review of the numbers of staff, skill mix and patient acuity and numbers. These "red flag events" include patients not being provided with basic care requirements, such as help with visits to the bathroom, being asked about pain levels or delays in providing medicines. The Senior Nurse Team considers any "red flag events" as indicators of the ward requiring an intervention e.g increasing staffing levels, facilitating patient discharge or closing to admissions for a temporary period following discussion and agreement with the Operations Centre and the Executive on call.

Chart 2 below shows the type and number of red flags raised for the reason 'shortfall in RN time' in August. The chart shows the highest number of red flags relate to shortfall in RN time. This is a decrease from the 34 'Shortfall in RN time' red flags in July. The use of red flags are correlating with other indicators, for example the late shift is when most staffing shortages are escalated, this is supported by the red triggering shift data.

Chart 2 – Red Flags by type

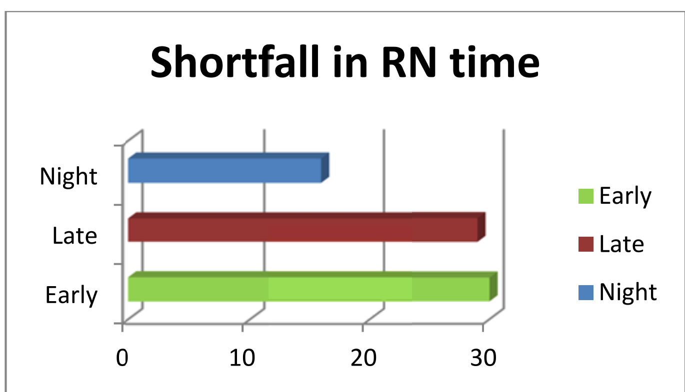
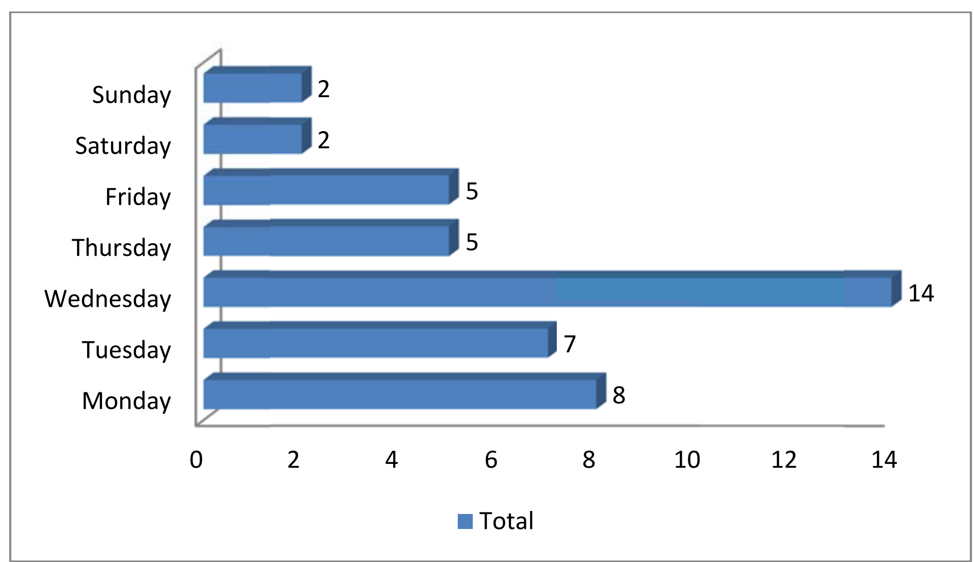


Chart 3 below indicates the red flags by day of the week; this shows that Monday, Tuesday and Wednesdays are the days where staffing is most likely to be escalated.

Chart 3 Red Flags Day/Night



4. The Board are assured of safe staffing for nursing across the organisation

The overall RN fill rate decreased in August and the subsequent number of unfilled shifts increased for the month. This is in part due to continued demand to cover higher than budgeted short notice sickness on the inpatient areas, drop in temporary staffing fill, increase in annual lease and the

sustained use of surge capacity areas to support increasing demand. The maintenance of safe staffing levels on wards in August was supported by:

- Continued daily monitoring and ward RAG rating of staffing levels across inpatient wards
- Red flags used to effectively escalate nationally reportable events to allow appropriate immediate action to be taken.
- Working with cap compliant agencies
- Working with agencies to identify long line agencies to support areas with high vacancies
- Challenge and confirm culture for all additional duties being added to roster
- Controlled release of unfilled shifts to agencies
- Improved reporting and monitoring through SafeCare and Red Flag process
- Additional support provided by e-Roster, NHSP and Temporary Staffing management to assist wards with staffing challenges
- Active management and support to review staffing requirements on a daily basis for identified wards
- NSMs, Matrons, Specialist Nurses and the Education Team have supported clinically where needed.

In addition the Director of Nursing is working with a national safer staffing group reviewing the guidance.

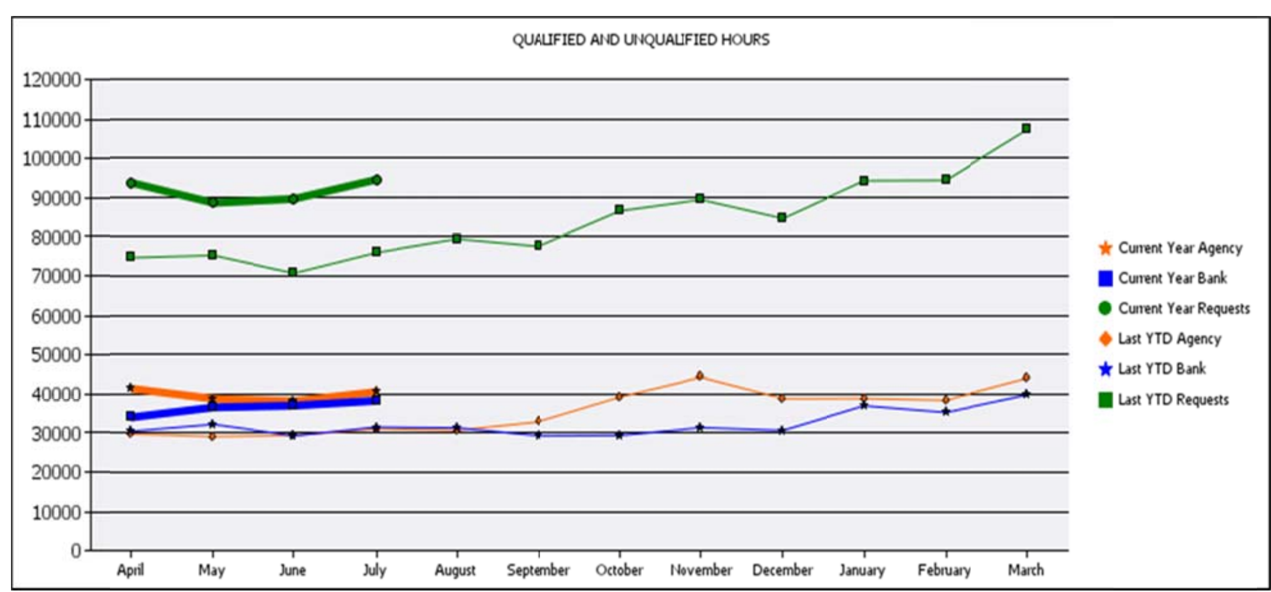
The Board are asked to note the data and supporting processes identified in this report which provide assurance of safe staffing levels in the Trust and the impact on patient safety.

Appendix 1

Ward name	Day		Night	
	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)
10B	93.3%	150.4%	91.6%	133.9%
11A	93.0%	118.9%	102.1%	205.5%
11B	94.9%	126.6%	97.1%	100.0%
5A	92.8%	89.5%	93.9%	106.8%
5B	94.7%	85.0%	89.7%	88.8%
6A	94.8%	129.1%	97.3%	105.9%
6B	94.1%	93.9%	98.0%	105.8%
7A Gynae	85.3%	111.7%	100.7%	93.9%
7B	89.1%	88.4%	94.8%	110.5%
7AN	62.6%	208.0%	95.3%	145.2%
8A	97.3%	91.7%	94.0%	93.8%
8B	83.7%	96.5%	99.5%	96.8%
9A	99.8%	131.4%	101.8%	153.8%
9B	91.6%	129.0%	99.3%	153.9%
ACU	94.2%	84.4%	108.5%	119.0%
AMU-A	100.3%	93.5%	80.1%	104.9%
AMU-W	87.7%	117.6%	99.2%	113.0%
Ashwell	90.1%	122.6%	98.1%	107.0%
Barley	89.2%	100.8%	96.0%	101.8%
Bluebell	85.7%	188.0%	91.6%	#DIV/0!
Critical Care 1	100.0%	100.0%	100.0%	100.0%
Dacre	86.4%	#DIV/0!	95.4%	#DIV/0!
Gloucester	98.2%	91.7%	97.5%	88.6%
CLU	99.1%	108.4%	100.0%	98.3%
Mat MLU	92.3%	106.2%	101.8%	113.1%
Michael Sobell House	102.3%	118.1%	95.4%	98.3%
Pirton	80.3%	81.9%	92.5%	95.6%
SAU	84.4%	83.5%	100.6%	103.8%
SSU	89.0%	111.1%	90.6%	117.3%
TC Swift	91.8%	88.5%	90.5%	98.2%
Ward 10	55.2%	91.3%	71.7%	#DIV/0!
Ward 11	79.5%	67.9%	82.2%	#DIV/0!
Total	**91.3%**	**107.5%**	**95.9%**	**111.6%**

Appendix 2

NHSP hours YTD report



Appendix 3

Shifts that initially triggered red in May 2016

Speciality	Ward	INITIAL REDS					
		Total no. of shifts available	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a Red rating
Care of the Elderly	9A	93	0	0	1	1	1.08
	9B	93	9	6	1	16	17.20
Stroke	Barley	93	3	3	0	6	6.45
	Pirton	93	4	8	1	13	13.98
General	6A	93	6	8	0	14	15.05
	10B	93	6	4	3	13	13.98
Respiratory	11A	93	2	6	0	8	8.60
	Escalation Ward	93	6	9	2	17	18.28
Cardiology	ACU	93	0	4	0	4	4.30
Acute	AMU-A	93	1	5	1	7	7.53
	SSU	93	8	9	2	19	20.43
	AMU-W	93	5	6	0	11	11.83
Renal	6B	93	4	5	2	11	11.83
DTOC / gastro	Ashwell	93	2	2	0	4	4.30
ED	A&E	93	4	12	3	19	20.43
	UCC	93	0	0	0	0	0.00
		1488	**60**	**87**	**16**	**163**	**10.95**
General	8A	93	1	1	0	2	2.15
	8B	93	9	11	1	21	22.58
	SAU	93	1	4	1	6	6.45
Surgical Spec	11B	93	2	2	0	4	4.30
	7B	93	6	6	0	12	12.90
T&O	5A	93	5	2	1	8	8.60
	5B	93	7	10	2	19	20.43
	TC Swift	93	0	1	1	2	2.15
ATCC	Critical Care 1	93	0	0	0	0	0.00
	ASCU	93	0	0	0	0	0.00
		930	**31**	**37**	**6**	**74**	**7.96**
Gynae	7A Gynae	93	1	2	1	4	4.30
Paeds	Bluebell	93	3	4	0	7	7.53
	Child A&E	93	0	2	3	5	5.38
	NICU	93	0	0	0	0	0.00
Maternity	Dacre	93	2	0	0	2	2.15
	Gloucester	93	0	1	0	1	1.08
	Mat MLU	93	1	1	0	2	2.15
	Mat CLU 1	93	1	2	0	3	3.23
		744	**8**	**12**	**4**	**24**	**3.23**
Inpatient	Ward 10	93	7	9	2	18	19.35
	Ward 11	93	5	7	1	13	13.98
	Michael Sobell House	93	1	0	2	3	3.23
		279	**13**	**16**	**5**	**34**	**12.19**
	TRUST TOTAL	**3441**	**112**	**152**	**31**	**295**	**8.57**

Appendix 4

Ward name	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
10B	3.23	2.99	6.22
11A	4.58	1.90	6.49
11B	4.09	3.02	7.11
5A	3.39	1.54	4.93
5B	3.37	2.04	5.41
6A	3.18	2.33	5.51
6B	4.27	2.99	7.26
7A Gynae	4.01	2.78	6.79
7B	3.31	1.61	4.92
7AN	3.34	3.12	6.46
8A	3.44	2.05	5.49
8B	3.69	1.84	5.53
9A	3.29	2.97	6.26
9B	3.20	3.02	6.22
ACU	5.96	2.73	8.69
AMU-A	7.75	4.68	12.43
AMU-W	4.65	3.97	8.63
Ashwell	3.38	2.79	6.17
Barley	4.14	2.69	6.84
Bluebell	9.12	1.93	11.05
Critical Care 1	28.79	2.44	31.22
Dacre	4.78	0.65	5.43
Gloucester	2.87	2.43	5.31
CLU	27.32	6.43	33.75
Mat MLU	4.38	1.37	5.75
Michael Sobell House	6.52	4.32	10.84
Pirton	4.86	2.54	7.40
SAU	7.55	3.11	10.66
SSU	3.50	2.59	6.09
TC Swift	3.72	2.50	6.23
Ward 10	5.19	2.41	7.60
Ward 11	8.83	2.29	11.12
Total	**4.9**	**2.6**	**7.5**

Infection Prevention and Control Board Report Objectives & Outcomes: September 2016

Objective	Narrative	Outcome	
1. Ensure that patients presenting with an infection or who acquire an infection during their care are identified promptly and receive appropriate management and treatment to reduce the risk of transmission.	1.1 In 2016-17, the Trust has a target of 0 avoidable MRSA Bacteraemias	1.1 Trust reported 0 MRSA hospital associated bacteraemias in July & August. Year to date position is 0 cases.	Green
	1.2 In 2016-17, the Trust has a target of no more than 11 cases of hospital acquired *C.difficile* infection	1.2 Trust reported 1 hospital acquired *C.difficile* case in July & 1 case in August. Year to date position is 9 hospital acquired cases, over trajectory by 4	Red
	1.3 In 2016-17, the Trust has had 8 cases of hospital acquired MSSA bacteraemia to date (no target set)	1.3 Trust reported 2 hospital acquired MSSA bacteraemias in July & 1 in August. Year to date position is 8 hospital acquired cases (no target set)	Green
	1.4 In 2016-17, the Trust has had 15 cases of hospital acquired E-Coli to date (no target set)	1.4 There were 2 cases of hospital acquired E.*coli* in July & 4 in August Year to date position is 9 hospital acquired cases (no target set)	Green
	1.5 In 2016-17, the Trust has identified 2 cases of Carbapenemase-producing Enterobacteriaceae (CPE) (no target set)	1.5 1 case of CPE identified in July & 1 case in August	Green
	1.7 Aim to minimise number and duration of outbreaks, eg Norovirus, through prompt identification and effective action	1.7 There were no outbreaks or periods of increased incidence in the Trust during July or August.	Green
	1.8 The Trust IPC Team uses ICNet for its identification, management and surveillance of HCAIs.	1.8 ICNet/TPP interface issues remain unresolved. Manual workaround implemented from beginning of October 2015 but some gaps in service have occurred. Potential solutions have now been identified and are being assessed. On Risk Register.	Red
2. Have in place and operate effective management systems for the prevention and control of HCAI	2.1 The Trust carries out mandatory Surgical Site Surveillance of infection rates for Total Knee Replacement (TKR), Total Hip Replacement (THR) and Fractured Neck of Femur Repair (#NOF)	2.1 The Trust was identified as an outlier for 2014-15 in all 3 categories. Figures for 2015-16 show an overall improvement particularly for #NOF, but the Trust remains an outlier for TKR & THR. Further work is being undertaken to reduce infection rates in line with national benchmarks.	Amber
3. Have and adhere to appropriate policies and protocols for the prevention and Control of HCAI	3.1 Fortnightly peer audits of High Impact Interventions to focus on aspects of clinical care (target over 95% for all areas). To identify good practice and any actions required will be put in place	3.1 Compliance figures for High Impact Interventions in July & August were above 95% with the exception of Surgical Site Observation , IV Devices Insertion (Aug only) & Continuing Care, Urinary Catheter Insertion (July only) & Continuing Care, Renal Environment and MRSA Screening (July only).	Amber

Section 1: Summary report

MRSA

2 MRSA bacteraemias were identified in the Trust in July, both in ED. Reviews were carried out and neither case was allocated to the Trust. There were no cases in August.

MSSA

2 MSSA Trust associated bacteraemias were identified in July. Both cases were reviewed and deemed to be unavoidable. The review of the August case found that this was not associated with an invasive device nor any identified lapses in care.

Clostridium difficile

RCAs have been held for the July and August cases. Both cases were isolated promptly and antimicrobial stewardship was good. Learning identified from the July case was that the patient did not have clinical disease but the stool sample was sent for testing following an inappropriate request from the Hertfordshire Community Trust team. This case is to be appealed. Learning identified for the August case was that there were gaps in stool chart documentation and delayed collection of stool sample.

Carbapenemase-producing Enterobacteriaceae (CPE)

Carbapenems are a class of broad spectrum intravenous antibiotics which are reserved for serious infections or when other therapeutic options have failed. One of the most concerning groups of Carbapenem Resistant Enterobacteriaceae (CRE) are those organisms which carry a carbapenemase enzyme that breaks down carbapenem antibiotics. This type of organism is called Carbapenemase Producing Enterobacteriaceae (CPE) and is the type which spreads most easily and has caused most outbreaks worldwide. In accordance with PHE guidance, a screening programme was introduced in the Trust in June 2014 to identify patients at high risk of CPE carriage. Any such patients are then tested and isolated until confirmed negative.

In July, a patient in the Critical Care Unit (CCU) tested positive for CPE. The patient did not meet the criteria for screening on admission, due to no recent travel or hospital admissions. The route of acquisition has not been identified. The patient had been isolated from admission, but all other patients in the department were screened as a precaution. All results were negative indicating no cross-transmission on CCU. An enhanced cleaning regime is currently in place in the area, and a programme admission and weekly screening has been introduced for all patients admitted to CCU.

In August, a renal inpatient was identified as CPE positive. The patient was admitted in June but not screened for CPE on admission as they did not meet screening criteria. The route of acquisition has not been identified. Precautionary screening has been implemented for all other patients on the ward. Two rounds of testing have been completed to date and all results are negative. Weekly screening of patients on the ward is to continue and will be reviewed in mid-September. Screening of all L&D Renal Satellite Unit patients is to be undertaken to determine prevalence of CPE within that community as they have been identified as highest risk for CPE carriage. Future screening for other renal populations will be considered in the light of the results of this screening initiative.

ICNet / TPP issues

Daily alert organism reports are being received by the IP&C Team for manual processing, pending the resolution of TPP/ICNet interface issues. However, some gaps in the interim manual reporting system have been identified, causing further concern about the ongoing lack of TPP/ICNet compatibility. ICNet has been commissioned to work with TPP to resolve the interface issues and a range of potential solutions have been identified which are currently being assessed. The situation is on the Risk Register.

Surgical Site Infection Surveillance

A Surgical Site Infection Working Group has been formed to revise and implement the Surgical Site Infection Action Plan. SSI figures for April 2015 – March 2016 show an overall reduction in infection rates, but the Trust remains an outlier in Knee Replacement and Hip Replacement. Figures for April - June 2016 are still being collated and verified results are due at end September. Figures for the last 4 quarters for which data has been collected are considered the most useful for identifying trends, due to the comparatively small number of patients per quarter. It should also be noted that data was collected for 1 quarter only during 2014-15 (Oct-Dec 2014).

HCAI / Antimicrobial Point Prevalence Survey

During October, the Trust will be participating in the national point prevalence survey of healthcare-associated infections and antimicrobial use in European acute-care hospitals. The survey is organised and supported by Public Health England as part of the European Centre for Disease Prevention and Control point prevalence survey. Teams comprising IP&C, Microbiology and Pharmacy staff will be collecting a wide range of data for all inpatient wards in the Trust during the two weeks commencing 10 & 17 October, and this will then be uploaded to the national database. Clinical areas will be informed of the timetable in advance.

Antimicrobial Stewardship

Antimicrobial CQUIN 2016-17: Performance to end August 2016

CQUIN criteria	Aim	Target	Trust position to end August 2016
CQUIN 4a	Reduction in total antibiotic consumption against the baseline	↓ 1% min	↓ 18%
CQUIN 4a	Reduction in carbapenem against the baseline	↓ 1% min	↑ 6%
CQUIN 4a	Reduction in piperacillin-tazobactam against the baseline	↓ 1% min	↓ 25%
CQUIN 4b (Q1)	Empiric review performed of cases in the sample	25% min	73%
CQUIN 4b (Q2)	Empiric review performed of cases in the sample	50% min	96%

Section 2: Data

Appendix 1: MRSA

Appendix 2: MSSA

Appendix 3: *Clostridium difficile*

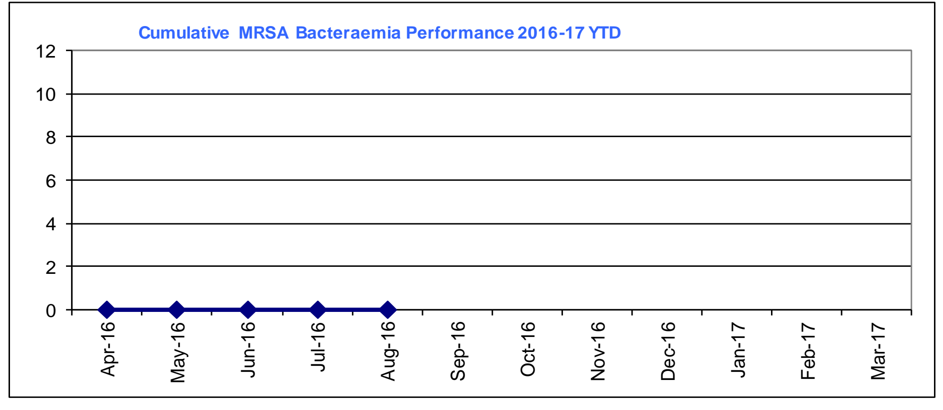
Appendix 4: Carbapenemase- producing Enterobacteriaceae (CPE)

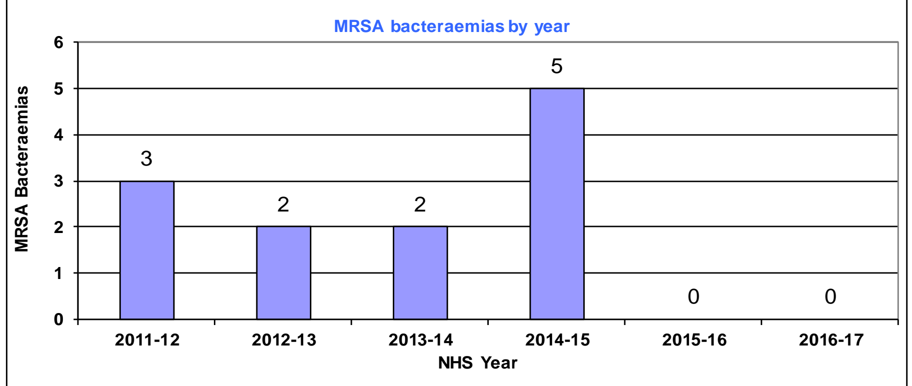
Appendix 5: *E. Coli*

Appendix 6: Surgical Site Surveillance

Appendix 7: High Impact Intervention audit scores

APPENDIX 1: MRSA BACTERAEMIA – POST 48 HRS





MRSA bacteraemia by Division

Division	YTD 2015-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD 2016-17
Cancer	0	0	0	0	0	0								0
Medicine	0	0	0	0	0	0								0
Surgical	0	0	0	0	0	0								0
Women & Children	0	0	0	0	0	0								0
Grand Total	0	0	0	0	0	0								0

MRSA – PHE Benchmarking Data (July 2016)

Public Health England

MRSA

Count of trust PIR assigned cases per month

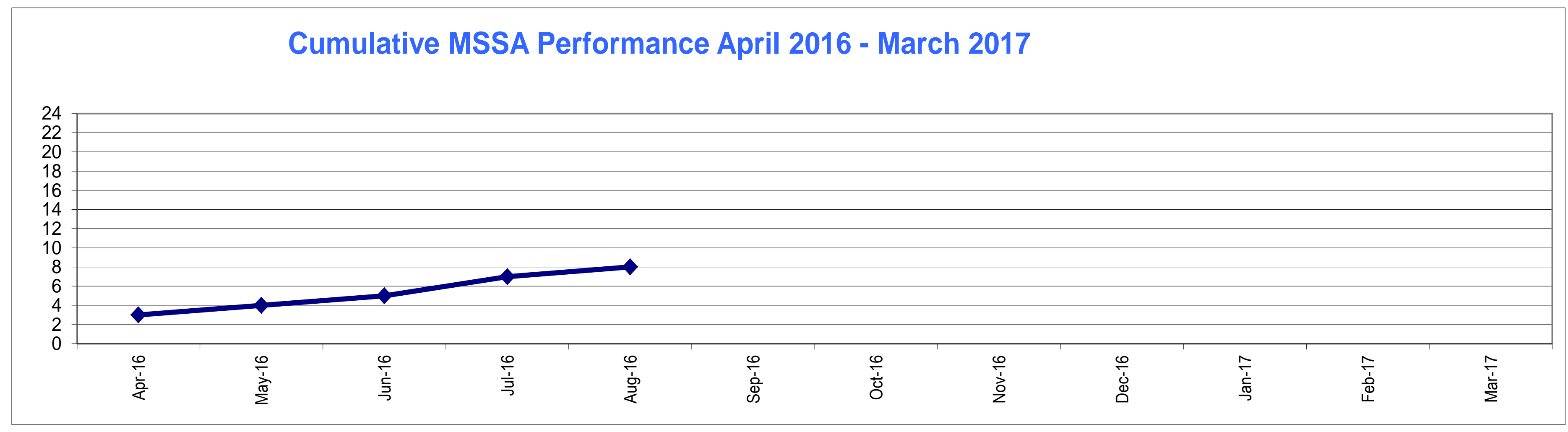
Trust Code	Acute Trust Name	Trajectory	2016 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2017 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0	0	0	0									**0**
RC1	Bedford Hospitals NHS Trust	N/A	0	0	0	0									**0**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0	0	0	0									**0**
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	1	0	0	0									**1**
RWH	East & North Hertfordshire NHS Trust	N/A	0	0	0	0									**0**
RQQ	Hinchingbrooke Health Care NHS Trust	N/A	0	0	0	0									**0**
RGQ	Ipswich Hospital NHS Trust	N/A	0	0	0	0									**0**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	0	0									**0**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	0	0									**0**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0	0	0	1									**1**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	0	0	0									**0**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0	0	0	0									**0**
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	0	0	0									**0**
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	N/A	0	0	0	1									**1**
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	0	0									**0**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	0	0	0									**0**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	0	0	0									**0**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	0	0	0									**0**
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0									**0**
	East of England Total	**N/A**	**1**	**0**	**0**	**2**									**3**
	England Total	**N/A**	**14**	**29**	**22**	**19**									**84**

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

Trust Code	Acute Trust Name	Trajectory	2016 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2017 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	6.30	0.00	0.00	0.00									**1.55**
RWH	East & North Hertfordshire NHS Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RQQ	Hinchingbrooke Health Care NHS Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RGQ	Ipswich Hospital NHS Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0.00	0.00	0.00	6.40									**1.63**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RGM	Papworth Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	6.02									**1.53**
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00									**0.00**
	East of England Total	**N/A**	**0.35**	**0.00**	**0.00**	**0.68**									**0.26**
	England Total	**N/A**	**0.40**	**0.82**	**0.64**	**0.54**									**0.60**

Please note that rates are calculated using **all cases** for CCGs and **acute trust apportioned/assigned cases** for trusts.

APPENDIX 2: MSSA BACTERAEMIA - POST 48 HRS



Hospital acquired MSSA by Division	YTD 2015-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD 2016-17
Cancer	0	0	0	0	0	0								0
Medicine	6	2	0	0	1	1								4
Surgical	5	1	1	0	1	0								3
Women & Children	2	0	0	1	0	0								1
MVCC	1	0	0	0	0	0								0
Grand Total	14	3	1	1	2	1								8

MSSA – PHE Benchmarking Data (July 2016)

Public Health England

MSSA

Count of all cases identified by acute trust per month

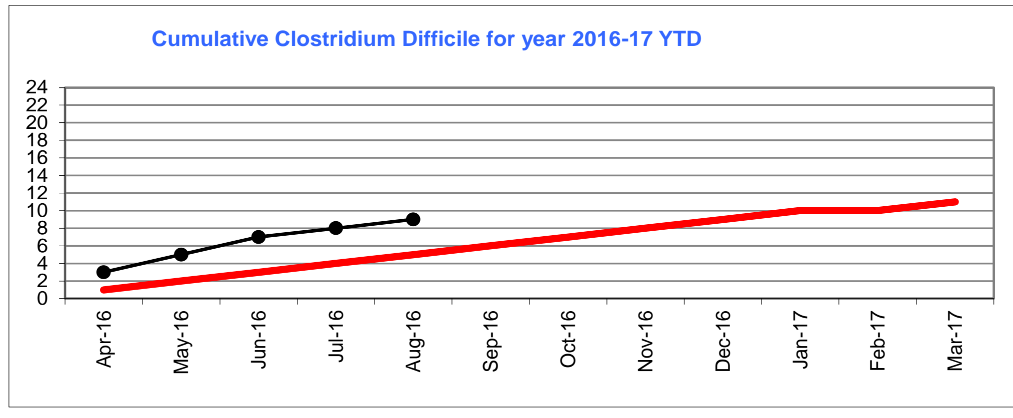
Trust Code	Acute Trust Name	Trajectory	2016									2017			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0	1	0	2									**3**
RC1	Bedford Hospitals NHS Trust	N/A	0	1	0	1									**2**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	3	3	1	4									**11**
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	2	3	1	0									**6**
RWH	East & North Hertfordshire NHS Trust	N/A	3	1	1	2									**7**
RQQ	Hinchingbrooke Health Care NHS Trust	N/A	1	1	3	1									**6**
RGQ	Ipswich Hospital NHS Trust	N/A	1	0	2	0									**3**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	1	1	0	2									**4**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	2	0									**2**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	2	1	1	0									**4**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	2	0	1	1									**4**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	2	0	2	0									**4**
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	1	0	1									**2**
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	N/A	1	0	2	1									**4**
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	2	0	2									**4**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	3	3	2	1									**9**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	2	1	0									**3**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	1	1	1	2									**5**
RGR	West Suffolk Hospitals NHS Trust	N/A	0	1	0	0									**1**
	East of England Total	**N/A**	**22**	**22**	**20**	**20**									**84**
	England Total	**N/A**	**269**	**252**	**297**	**223**									**1041**

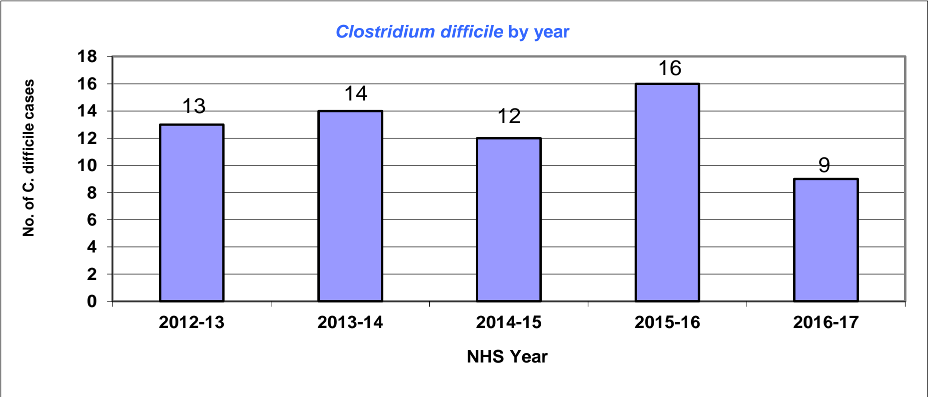
Monthly rate per 100,000 occupied bed days (acute trust apportioned cases only)

Trust Code	Acute Trust Name	Trajectory	2016									2017			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0.00	4.99	0.00	9.98									**3.81**
RC1	Bedford Hospitals NHS Trust	N/A	0.00	8.74	0.00	8.74									**4.44**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	11.57	11.19	3.86	14.93									**10.43**
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	12.61	18.30	6.30	0.00									**9.30**
RWH	East & North Hertfordshire NHS Trust	N/A	17.04	5.50	5.68	10.99									**9.78**
RQQ	Hinchingbrooke Health Care NHS Trust	N/A	18.39	17.80	55.18	17.80									**27.14**
RGQ	Ipswich Hospital NHS Trust	N/A	6.90	0.00	13.80	0.00									**5.09**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	9.26	8.96	0.00	17.92									**9.11**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	0.00	11.68	0.00									**2.87**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	13.22	6.40	6.61	0.00									**6.50**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	14.73	0.00	7.36	7.13									**7.24**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	7.02	0.00	7.02	0.00									**3.45**
RGM	Papworth Hospital NHS Foundation Trust	N/A	0.00	18.21	0.00	18.21									**9.25**
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	N/A	6.22	0.00	12.43	6.02									**6.12**
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	15.09	0.00	15.09									**7.67**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	21.05	20.37	14.03	6.79									**15.53**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0.00	16.71	8.63	0.00									**6.37**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	5.38	5.21	5.38	10.42									**6.62**
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	8.73	0.00	0.00									**2.22**
	East of England Total	**N/A**	**7.73**	**7.48**	**7.03**	**6.80**									**7.26**
	England Total	**N/A**	**7.61**	**7.13**	**8.66**	**6.29**									**7.41**

Please note that rates are calculated using **all cases** for CCGs and **acute trust apportioned/assigned cases** for trusts.

APPENDIX 3: CLOSTRIDIUM DIFFICILE – HOSPITAL ACQUIRED





Trajectory: Actual:

C-DIFF by Division

Division	YTD 2015-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD 2016-17
Cancer	0	0	0	0	0	0								0
Medicine	12	3	2	2	1	1								9
Surgical	4	0	0	0	0	0								0
Women & Children	0	0	0	0	0	0								0
Grand Total	16	3	2	2	1	1								9

C.DIFFICILE – PHE Benchmarking Data (July 2016)

Public Health England

Clostridium difficile

Count of acute trust apportioned cases per month

Trust Code	Acute Trust Name	Trajectory	2016									2017			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	31	0	2	2	5									**9**
RC1	Bedford Hospitals NHS Trust	10	1	1	2	0									**4**
RGT	Cambridge University Hospitals NHS Foundation Trust	49	3	1	3	8									**15**
RDE	Colchester Hospitals University NHS Foundation Trust	18	4	4	4	2									**14**
RWH	East & North Hertfordshire NHS Trust	11	3	2	2	1									**8**
RQQ	Hinchingbrooke Health Care NHS Trust	11	1	2	1	0									**4**
RGQ	Ipswich Hospital NHS Trust	18	1	7	2	1									**11**
RGP	James Paget University Hospitals NHS Foundation Trust	17	0	1	1	0									**2**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	6	1	0	2	3									**6**
RQ8	Mid Essex Hospital Services NHS Trust	13	4	3	1	1									**9**
RD8	Milton Keynes Hospital NHS Foundation Trust	39	2	0	0	3									**5**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	49	4	2	4	6									**16**
RGM	Papworth Hospital NHS Foundation Trust	5	1	0	0	0									**1**
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	29	3	1	3	2									**9**
RQW	Princess Alexandra Hospital NHS Trust	10	2	0	2	2									**6**
RAJ	Southend University Hospital NHS Foundation Trust	30	0	0	1	1									**2**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	53	3	0	2	4									**9**
RWG	West Hertfordshire Hospitals NHS Trust	23	0	3	1	3									**7**
RGR	West Suffolk Hospitals NHS Trust	16	2	1	3	3									**9**
	East of England Total	**413**	**35**	**30**	**36**	**45**									**146**
	England Total	**4483**	**356**	**389**	**362**	**393**									**1500**

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

Trust Code	Acute Trust Name	Trajectory	2016									2017			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	13.60	0.00	9.98	10.32	24.96									**11.42**
RC1	Bedford Hospitals NHS Trust	8.30	9.03	8.74	18.06	0.00									**8.88**
RGT	Cambridge University Hospitals NHS Foundation Trust	15.60	11.57	3.73	11.57	29.85									**14.22**
RDE	Colchester Hospitals University NHS Foundation Trust	9.10	25.22	24.40	25.22	12.20									**21.70**
RWH	East & North Hertfordshire NHS Trust	4.90	17.04	10.99	11.36	5.50									**11.17**
RQQ	Hinchingbrooke Health Care NHS Trust	15.60	18.39	35.60	18.39	0.00									**18.09**
RGQ	Ipswich Hospital NHS Trust	9.40	6.90	46.74	13.80	6.68									**18.66**
RGP	James Paget University Hospitals NHS Foundation Trust	13.10	0.00	8.96	9.26	0.00									**4.55**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	3.10	5.84	0.00	11.68	16.95									**8.61**
RQ8	Mid Essex Hospital Services NHS Trust	7.30	26.44	19.19	6.61	6.40									**14.63**
RD8	Milton Keynes Hospital NHS Foundation Trust	25.80	14.73	0.00	0.00	21.38									**9.05**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	15.10	14.04	6.79	14.04	20.38									**13.81**
RGM	Papworth Hospital NHS Foundation Trust	7.00	18.81	0.00	0.00	0.00									**4.63**
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	14.40	18.65	6.02	18.65	12.03									**13.76**
RQW	Princess Alexandra Hospital NHS Trust	6.50	15.59	0.00	15.59	15.09									**11.50**
RAJ	Southend University Hospital NHS Foundation Trust	17.30	0.00	0.00	7.02	6.79									**3.45**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	38.00	25.90	0.00	17.27	33.42									**19.11**
RWG	West Hertfordshire Hospitals NHS Trust	10.90	0.00	15.63	5.38	15.63									**9.27**
RGR	West Suffolk Hospitals NHS Trust	12.50	18.05	8.73	27.08	26.20									**19.97**
	East of England Total	**13.70**	**12.30**	**10.20**	**12.65**	**15.30**									**12.61**
	England Total	**13.13**	**10.07**	**11.01**	**10.55**	**11.09**									**10.68**

Please note that rates are calculated using **all cases** for CCGs and **acute trust apportioned/assigned cases** for trusts.

APPENDIX 4: CARBAPENEMASE-PRODUCING ENTEROBACTERIACEAE

Carbapenemase-Producing Enterobacteriaceae

Division	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD 2015-16
Cancer	0	0	0	0	0								0
Medicine	0	0	0	0	1								1
Surgical	0	0	0	1	0								1
Women & Children	0	0	0	0	0								0
MVCC	0	0	0	0	0								0
Grand Total	**0**	**0**	**0**	**1**	**1**								**2**

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

APPENDIX 5: E.COLI BACTERAEMIA – POST 48 HRS

Hospital Acquired E.Coli by Division

Division	YTD 2015-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD 2015-16
Cancer	1	0	0	0	0	0								0
Medicine	17	1	1	1	1	1								5
Surgical	6	3	2	0	1	3								9
Women & Children	0	0	0	0	0	0								0
MVCC	0	1	0	0	0	0								1
Grand Total	**24**	**5**	**3**	**1**	**2**	**4**								**15**

E.COLI – PHE Benchmarking Data (July 2016)

Escherichia coli

Note: PHE figures for E.coli are not split between hospital-acquired and community-acquired cases

Trust Code	Acute Trust Name	Trajectory	2016									2017			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	17	17	17	23									**74**
RC1	Bedford Hospitals NHS Trust	N/A	11	7	10	9									**37**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	22	27	24	20									**93**
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	20	29	25	24									**98**
RWH	East & North Hertfordshire NHS Trust	N/A	27	21	25	24									**97**
RQQ	Hinchingbrooke Health Care NHS Trust	N/A	9	9	9	11									**38**
RGQ	Ipswich Hospital NHS Trust	N/A	18	11	17	23									**69**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	13	21	15	18									**67**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	19	18	17	18									**72**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	21	15	23	16									**75**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	16	12	17	20									**65**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	24	31	29	39									**123**
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	1	0	2									**3**
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	N/A	15	15	10	17									**57**
RQW	Princess Alexandra Hospital NHS Trust	N/A	18	10	19	9									**56**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	19	12	19	21									**71**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	14	11	21	24									**70**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	11	14	14	24									**63**
RGR	West Suffolk Hospitals NHS Trust	N/A	9	8	14	15									**46**
	East of England Total	**N/A**	**303**	**289**	**325**	**357**									**1274**
	England Total	**N/A**	**3047**	**3361**	**3405**	**3617**									**13430**

APPENDIX 6 : Surgical Site Infection Rates

Category	2011-15 National Benchmark	2014-15 ENHT	No. infections / ops	Jan-Mar 2016 ENHT	No. infections / ops	Last 4 Periods ENHT	No. infections / ops
Total Knee Replacement	**0.6%**	**6.3%**	5 / 80	**3.7%**	2 / 54	**2.5%**	6 / 238
Total Hip Replacement	**0.7%**	**4%**	4 / 101	**3.2%**	3 / 94	**2.1%**	8 / 386
Repair Fractured Neck of Femur	**1.4%**	**4.2%**	5 / 118	**1.2%**	1 / 81	**1.1%**	4 / 359

ENHT Surgical Site Infection rates

%	ENHT 2014-15	ENHT Apr-Jun 2015	ENHT Jul-Sept 2015	ENHT Oct-Dec 2015	ENHT Jan-Mar 2016	ENHT Last 4 periods
Total Knee Replacement	6.3	3.2	1.6	1.8	3.7	2.5
Total Hip Replacement	4	1.9	2	1.1	3.2	2.1
Repair to Fractured Neck of Femur	4.2	0	3.5	0	1.2	1.1

APPENDIX 7 : High Impact Intervention Audit Scores

High Impact Interventions	YTD 2015-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD 2016-17	RAG rate (Month on Month)
Hand Hygiene	95.63%	95.81%	97.16%	97.98%	96.91%	97.10%								96.90%	▲
Surgical Site Observation	95.32%	95.85%	96.34%	96.31%	92.69%	89.71%								94.43%	▼
Intravascular Devices (Insertion)	95.05%	97.63%	97.49%	95.66%	97.11%	92.90%								96.10%	▼
Intravascular Devices (Continuing Care)	90.70%	94.66%	93.82%	89.12%	90.16%	87.91%								90.79%	▼
Urinary Catheter (Insertion)	94.96%	96.69%	97.93%	97.64%	93.16%	96.36%								96.45%	▲
Urinary Catheter (Continuing Care)	92.50%	96.88%	97.42%	97.12%	93.39%	92.86%								95.99%	▼
Renal Dialysis (Continuing Care)	98.33%	95.46%	98.69%	98.18%	98.38%	96.97%								97.61%	▼
Ventilator (Continuing Care)	99.33%	100.00%	100.00%	100.00%	100.00%	97.84%								98.27%	▼
Environment (Inpatients)	96.87%	98.13%	97.52%	97.39%	97.13%	97.18%								97.60%	▲
Environment (Outpatients)	96.82%	96.05%	97.95%	97.54%	96.81%	96.83%								97.04%	▲
Environment (Renal Dialysis)	91.58%	89.41%	86.33%	90.49%	90.56%	86.00%								87.93%	▼
MRSA Screening Compliance	91.61%	97.05%	95.63%	94.83%	93.09%	96.97%								95.19%	▲

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