East and North Hertfordshire NHS Trust
Trust Board - Public Meeting

Hertford County Hospital

6 November 2019 11:00 - 6 November 2019 12:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	11:00
2	Apologies for Absence: PC		
3	Declaration of Interests	All	
4	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 (joseph.maggs@nhs.net), by telephone (01438 285454) or by post to: Trust Secretary, Lister Hospital, Coreys Mill Lane, Stevenage, Herts, SG1 4AB. Each person will be allowed to 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.		
5	Minutes of Previous Meeting For approval 5. Minutes of Public Trust Board Meeting 4.9.19.pdf 7	Chair	
6	Patient Testimony For discussion	Director of Nursing	11:05
7	Chief Executive's Report For discussion 7. CE Board Report November 2019.pdf 19 7. NHS-Providers-pre-election-period-briefing-gene... 23	Chief Executive	11:20

#	Description	Owner	Time
8	**Quarterly Divisional Progress Report on Clinical Strategic Priorities** For discussion 8. Clinical Strategy Q2 2019-20 Progress Report.pd... 29 8. Appendix 1.pdf 37	Director of Strategy	11:25
9	**Integrated Performance Report** For discussion 9. IPR Month 6.pdf 83	All Executive Directors	11:35
10	**Finance and Performance Committee Report to Board** For discussion 10. (a) FPC Report to Board - 25.09.2019.pdf 133 10. (b) FPC Report to Board - 30.10.2019.pdf 137	Chair of FPC	11:55
10.1	**FPC Annual Review and Terms of Reference** For approval 10.1 Annual Review of Finance and Performance C... 141 10.1 Appendix 1.pdf 149	Chair of FPC	
11	**Quality and Safety Committee Report to Board** For discussion 11. (a) QSC Report to Board - 24 Sept 2019.pdf 153 11. (b) QSC Report to Board - 29 Oct 2019.pdf 159	Chair of QSC	12:00
11.1	**Actions from previous patient testimony (to follow)** For information	Director of Nursing	
11.2	**Quality and Safety Committee Annual Review and Terms of Reference** For aproval 11.2 QSC Annual Review 2018-19.pdf 165 11.2 Appendix 1 QSC ToR.pdf 173	Chair of QSC	

#	Description	Owner	Time
12	Audit Committee Report to Board For discussion 12. Audit Comm Report to Board - 28 October 2019... 177	Chair of Audit Committee	12:15
12.1	Audit Committee Annual Review and Terms of Reference For approval 12.1 Audit Committee Annual Review.pdf 183	Chair of Audit Committee	
12.2	Trust Standing Orders and Standing Financial Instructions For approval 12.2 Standing Orders and Standing Finanical Instru... 197	Director of Finance / Associate Director of Corporate Governance	
13	Board Assurance Framework For discussion 13 BAF Report.pdf 321 13. Appendix 1.pdf 323	Associate Director of Corporate Governance	12:20
14	Annual Cycle For information 14. Board Annual Cycle 2019-20.pdf 343	Associate Director of Corporate Governance	12:30
15	Matters Arising and Actions Log For information 15. Public Trust Board Actions Log.pdf 347	Chair	12:35
16	Data Pack For information 16. Data Pack.pdf 349		
17	REPORTS FOR NOTING		
17.1	Charity Trustee Committee Report to Board For discussion 17.1 CTC Report to Board - 09.09.19.pdf 375	Chair of CTC	

#	Description	Owner	Time
17.1.1	Charity Trustee Committee Annual Review and Terms of Reference For approval [P] 17.1.1 CTC Annual Review 2018-19.pdf 379	Chair of CTC	
17.2	Charity Annual Report and Accounts 2018-19 For approval [P] 17.2 (a) Charity Annual Report and Accounts Cover... 387 [P] 17.2 (b) Charity Annual Report 2019 V.2 final.pdf 389 [P] 17.2 (c) East and North Herts NHST Charitable Fun... 421 [P] 17.2 (d) Letter of Representation.pdf 449	Chair of CTC	
17.3	Flu vaccination self-assessment For information [P] 17.3 Staff Flu Vaccination Self-Assessment.pdf 453	Chief People Officer	
17.4	Learning from Deaths Report For information [P] 17.4 Learning from Deaths Report.pdf 455	Medical Director	
17.5	Nursing, Midwifery and AHP Strategy Progress Report For information [P] 17.5 Nursing, Midwifery and AHP Strategy Progres... 471	Director of Nursing	
18	Date of next meeting: 8 January 2020, Lister Education Centre, Lister Hospital (11:00 am)		

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 4 September 2019 at 11.00 am at Postgraduate Centre, Mount Vernon Cancer Centre, Northwood.

Present:	Mrs Ellen Schroder	Non-Executive Director (Chair)
	Dr David Buckle	Non-Executive Director – Associate
	Dr Peter Carter	Non-Executive Director
	Mrs Karen McConnell	Non-Executive Director
	Mr Bob Niven	Non-Executive Director
	Mr Jonathan Silver	Non-Executive Director
	Mr Nick Carver	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance
	Dr Michael Chilvers	Medical Director
	Ms Rachael Corser	Director of Nursing
	Ms Julie Smith	Chief Operating Officer
In attendance from the Trust:	Mr Duncan Forbes	Chief People Officer
	Ms Sarah Brierley	Director of Strategy
	Ms Clair Hartley	Corporate Governance Officer (Minutes)
	Mr Joseph Maggs	Trust Secretary
	Mr Martin Gray	East & North Hertfordshire NHS Trust (observing)
In attendance external to the Trust:	Mr Steve Palmer	Healthwatch, Herts
	Dr Linda Sheridan	Non-Executive Director, Hertfordshire Community NHS Trust
	Mr Alex Shearman	Imperial College NHS Trust
For patient testimony:	Mr Mick Wilkinson	Member of Public
	Mr Peter Wilkinson	Member of Public
	Ms Sue Wilkinson	Member of Public
	Ms Nicki Bangert	Member of Public

19/082 CHAIR'S OPENING REMARKS

19/082.1 Mrs Schroder welcomed the members of the public to the meeting and thanked them for attending.

19/083 APOLOGIES FOR ABSENCE

19/083.1 Apologies for absence were received from Ms Val Moore (Non-Executive Director).

19/084 DECLARATIONS OF INTEREST

19/084.1 There were no declarations of interest.

19/85 QUESTIONS FROM THE PUBLIC

19/085.1 No questions had been received from the public.

19/086 MINUTES OF PREVIOUS MEETING

19/086.1 The Board reviewed and approved the draft minutes of the previous meeting of 3 July 2019 as an accurate record of the meeting subject to a few spelling errors.

19/087 PATIENT TESTIMONY

19/087.1 Dr Carter introduced the family of Janice Wilkinson to the Board. Mr M Wilkinson, Mr P Wilkinson, Ms N Bangert and Ms S Wilkinson were present for the discussion.

19/087.2 Mr M Wilkinson provided the Board with an introduction regarding his sister, Janice Wilkinson. He provided the Board with an insight into her life and interests and explained that Janice had physical and mental challenges that would have been difficult for many to overcome. Her approach to life was a testament to her character.

He advised that his sister had passed away within two days of attending the Lister hospital in February 2018.

19/087.3 He explained that a concern had been raised by a member of staff about Janice's care and the family would have been unaware of any issues regarding her care were it not for this member of staff. He explained that the family were attending the Board meeting to prevent similar incidents affecting vulnerable patients.

19/087.4 He explained that following Janice's death, the Trust's approach had made the situation more difficult and challenging. The problems he highlighted included issues with the SI process, such as unfamiliarity with the SI framework by some staff members and under resourcing of this function.

He also expressed that the family felt they had not been listened to throughout the process, with a number of questions going unanswered. Additionally they had to regularly chase the Trust for updates, with the Trust missing all the deadlines that were agreed.

19/087.5 Mr M Wilkinson noted that the family had often identified inaccuracies in the notes of the meetings they had attended. The family had also questioned the independence of the member of staff

allocated to sign off the report.

The family were particularly disappointed with insensitive language that had been used at some of the meetings. This included questioning the source of information used by the family and a member of staff using the term 'low functional baseline'.

19/087.6 Mr M Wilkinson concluded that whilst resources are constrained, in his view the Trust must do better in ensuring that the most vulnerable patients do not receive an inferior service. He posed the following challenges to the Board:

- To publish at Board level the actions previously agreed regarding this case;
- To publish the results of the SI investigation;
- To publish the measures and performance indicators outlined to the family and Herts County Council earlier this year;
- To provide confidence and evidence that the SI process has been strengthened and is fit for purpose;
- To consider how this process can continue to improve over time;
- To provide details of how the Learning Disability support team has been strengthened;
- To take a lead in seeing where other trusts to may be making similar decisions.

19/087.7 Dr Carter thanked the family for providing the Board with this information and paid tribute to the family for coming forward and raising their concerns.

The Chief Executive also expressed his thanks to the family for attending the meeting and sharing their experiences. He was disappointed to hear that the Trust's processes had made the situation more difficult. He agreed that it was right that the Board should respond to points made by Mr M Wilkinson and committed to bringing a public response to the next Board meeting.

19/087.8 Mrs Schroder explained that the Board needed to be assured that the Trust's systems worked effectively and that on this occasion they had not. She confirmed that the Board would endeavour to ensure that the learning had taken place.

The Director of Strategy commented that the attitude of staff could have made a significant difference to the family's experience.

19/087.9 The Medical Director explained that a new medical examiner system was being introduced nationally. This new system would offer a point of contact for bereaved families to raise concerns about the care provided prior to the death of a loved one.

19/087.10 Regarding the incident investigation process, the Director of Nursing explained that the Trust had made a significant investment in the team to ensure they have the skills and capacity to provide the service.

19/087.11 Mr M Wilkinson suggested that the team investigating incidents should have direct access to senior management within the Trust.

The Director of Nursing advised that they were now based in close proximity to the executive directors.

19/087.1 Mrs Schroder concluded that the Board would provide a personal response to the specific points related to this case and a general explanation of how the processes have been strengthened. These would be published with the papers for the next Board meeting. **Director of Nursing, Medical Director**

19/088 CHIEF EXECUTIVE'S REPORT

19/088.1 The Chief Executive's report contained the following highlights:

1. CQC Inspection Update

He reported that after the initial inspection, the CQC had paid a few unannounced visits to Lister hospital and a few to MVCC as well. The preliminary feedback was mostly positive. The CQC Well Led Inspection would be held on 10th and 11th of September.

19/088.2 **2. Corporate Update:**

The Trust has been recognised as a top employer for people who have served in the armed forces, and those who are reservists. The Trust had been a silver rated organisation for support to the armed forces for about a decade. It had now been rated as gold as an armed forces employer. The Trust was proud of this achievement. A member of the Royal Family would present the award.

19/088.3 The Mount Vernon Cancer Centre (MVCC) Clinical Advisory Group had published its report containing recommendations. The Chief Executive welcomed the report and expressed the hope that the problems created by the lack of capital investment in the site would be resolved in order that an improved service could be provided to patients.

19/088.4 **2. Our Staff**

The Chief Executive welcomed the new Head of Communication and Engagement, Eilidh Murray to the Trust.

19/088.5 Three consultants had received an Excellence in Medical Education Award. ED nurse, Yvonne Pearse had been awarded Mentor of the Year.

19/89 Divisional Reporting of Clinical Strategy Priorities

19/089.1 The Director of Strategy updated the Board on the progress made by Divisions against delivery of their Clinical Strategic Priorities. The report covered progress made in Q1 of 2019/20.

19/089.2 Each Division's highlight report was appended. The report gave an initial overview of progress against each clinical strategic priority and then a short update against each key action, including progress to date, any risks to delivery and issues to escalate for support.

19/089.3 The papers were taken as read. A common thread highlighted by the updates was capital limitations and the Trust was looking at ways to generate capital for the necessary projects.

19/089.4 Mrs Schroder commented that the Board should concentrate on the issues that were escalated in the body of the report as the

appendices were too detailed for consideration at the meeting and would be part of a future Deep Dive.

19/089.5 Mrs Schroder suggested that proposals for requests for capital should be prepared so that they could be ready for submission on short notice where necessary.

19/089.6 Mrs Schroder suggested that in future the report could include details of the actions being taken to address the escalations. The Director of Strategy agreed the next report could include more narrative and welcomed feedback from others.

19/089.7 The Director of Finance said there was a need to be honest about finances and undertake a thorough stocktaking on what was needed, what the real weakness were and what needed to be addressed urgently in terms of capital planning

The Chief Operating Officer suggested that the report could include the link to operations and performance in future.

Mrs McConnell said that when stocktaking had been done, the Trust would be aware of the number of risks and could see how they were interrelated.

19/090 MVCC - Strategic Review Update

19/090.1 The report was submitted to provide an update regarding the strategic review into the sustainability of oncology services provided by the Mount Vernon Cancer Centre (MVCC).

19/090.2 In January 2019 NHS England agreed with the Trust and the East of England and London Cancer Alliances to undertake a strategic review of the oncology services provided at Mount Vernon Cancer Centre (MVCC) as a result of concerns raised by the Trust and other stakeholders regarding the long term sustainability of the service and the environment from which services were delivered. The Trust had worked with the strategic review team and supported them where necessary.

19/090.3 An independent clinical advisory group review was undertaken in June 2019. Following their review the Clinical Advisory Group (MVCAG) published their report, which made the following recommendations, amongst others:

- that the accountability and ownership of the MVCC services be transferred from the Trust to a current tertiary cancer centre;
- that a MVCC clinical consultant lead be appointed to help manage the transition with the existing team.

19/090.4 The Director of Strategy reported that the MVCAG did a thorough piece of work, spoke to a number of stakeholders and produced a report at the end of their investigation. The Trust welcomed the proposal that MVCC be transferred to a tertiary cancer centre.

19/090.5 Dr Carter said that it was important to engage staff to be clear that the process was not about job losses. Mr Niven asked about the identity of the new tertiary provider and the time scale for implementation of the recommendations. The Director of Strategy

replied that they were in the process of identifying a provider and hoped it would be a short process but there also needed to be a process of due diligence.

19/090.6 Dr Buckle asked whether the clinical consultant lead referred to in the recommendations had been identified as he believed that it was important that the lead be appointed without delay. The Medical Director replied that there was currently a clinical director in place and they were looking at options to address that recommendation.

19/091 Integrated Performance Report

19/091.1 The Integrated Performance Report for month 4 was presented to the Board.

19/091.2 *Safe*

19/091.3 The Director of Nursing presented the updates on safe & caring services.

19/091.4 There was one Never Event reported in July. A patient was given air instead of oxygen, resulting in low harm. A total of eight serious incidents were reported in July, 4 relating to recognition and management of the deteriorating patient, 1 related to harm from a fall, 2 related to delayed diagnosis and 1 related to abnormal imaging.

19/091.5 New measurement of sepsis care had been undertaken in quarter 1 of 2019/20. Timeliness of treatment with sepsis six had commenced.

There was an ongoing review of processes to improve governance and measurement of VTE risk assessments.

19/091.6 Mr Silver asked why there had been such a large increase in the incidences of *c.diff* infections. The Director of Nursing replied that this was due to the change in national reporting.

19/091.7 *Caring*

19/091.8 Since April 2019 an average of 71% of complaints across the divisions had been responded to within the agreed timeframe. This was an ongoing challenge. The Trust was trying very hard to ensure that the target was reached.

19/091.9 *Effective*

19/091.10 The Medical Director reported that mortality rates had improved over the last five years as measured by both HSMR and SHMI. HSMR remained in the better than expected range. HSMR showed no outliers. With regard to SHMI there were two outliers which were being investigated and addressed.

In regard to re-admissions, there had been a consistent improving trend. However the re admission figures had risen recently.

19/091.11 The quarterly learning from death report included a summary of key themes emerging from the cases. This detail was shared with all Trust Specialities and with interested working groups. There would soon be EOL aspects on dashboard and a 7 days services working group was commencing the following day.

19/091.12 *Responsive*

19/091.13 The Chief Operating Officer presented the report.

19/091.14 *A&E Performance*

19/091.15 July had been a challenging month. A & E performance deteriorated to 81.47%. No 12-hour trolley waits were reported in July. The period of significant heat had caused increased demand on the Emergency department, impacting on patient flow and resources. Incident management processes had been put in place. The Trust had also experienced two unscheduled IT outages which put strain on operational performance.

19/091.16 ED recorded one of the busiest months in June. A record number of 478 patients presented at ED. The Trust was recording the patient's postal codes and demographics and intended to share this with the CCG to see where the patients came from and to better anticipate and plan for the likely demand for services in the future.

19/091.17 The Trust was planning for winter by reviewing and strengthening ambulatory care services. Work would be taking place in three pathways: surgical, medical and frailty.

19/091.18 *Cancer:*

19/091.19 The Trust 62-day performance for June 2019 was 75.6% which was below the 78.7% revised trajectory. The trust was committed to delivering the revised trajectory. Four out of nine tumour sites met the target, with 17 breaches. In June 2019 three out of 11 tumour sites met the standard with 45% of avoidable breaches occurring in urology.

19/091.20 *RTT*

19/091.21 Performance had improved but remained below the target of 89.3%. The focus was on reducing reportable 52-week breaches to zero by the end of October 2019.

19/091.22 *Diagnostics:*

19/091.23 Diagnostics performance in July remained compliant at 0.56% and was not raising risks.

19/091.24 *Stroke:*

19/091.25 There was a slight deterioration in stroke performance. Bed occupancy was a challenge. The reservation of stroke beds was challenging. Performance for July was 63.30%, an improvement from the April/May performance.

19/091.26 *Winter*

19/091.27 A steering group was set up to plan for winter. This aligned with the previous year's planning. Staff had come up with some good ideas already.

19/091.28 Mrs Schroder commented on the staffing of additional winter beds. The Director of Nursing replied that she recognised the need for experienced staff to provide care.

19/091.29 Mrs Schroder asked if the Trust was an outlier on long stay patients. The Chief Operating Officer replied that long stayers were being reviewed on a weekly basis to solve problems. The Trust was performing well but there was potentially an opportunity to do more.

19/091.30 Mrs Schroder commented that more support from the county and STPs would be helpful. The Medical Director said that patients should not need to be kept in hospital simply to administer antibiotics twice a day. Patients should not be kept in hospital unnecessarily.

19/091.31 *Well- led*

19/091.32 The Chief People Officer presented the report. There were a number of key issues regarding staff. There was a continuing challenge on payroll. Some initiatives to reduce the payroll were bearing fruit, others were a longer challenge. Several initiatives to reduce dependency on bank and agency staff were being explored. Increased efficiency was planned through use of E-rostering to reduce use of bank and agency staff. E-rostering master classes had begun.

19/091.33 Acute medicine was a challenge. Bank and agency spending had increased but the Trust was confident that it could meet the ceiling target.

19/091.34 Overall sickness absence rate remained the same but was on target. The turnover rate continued to improve. Appraisal compliance increased to 86.3% against a target of 90 but had not hit the planned improvement trajectory of 10 out of 15. Mandatory training modules were on target. Overall compliance reduced by 1%.

19/091.35 Mrs Schroder remarked that it was good that the vacancy rate had been reduced below 6%.

19/091.36 Mr Silver asked whether failure to cut back on temporary staff-spend was the reason for the pay-bill variance. The Director of Finance replied that many areas of the pay bill were well managed but there was an issue with others. There was a cultural issue of locum doctors who were working for the Trust for years no longer feeling like temporary staff. Medical rostering improvements would be a big step forward.

19/091.37 Dr Carter said that it was counterintuitive that they were doing well on recruitment and sickness but the pay bill was up. The Director of Finance stated that there had been a shift from agency to bank but there were still costs associated with bank.

19/091.38 The Chief People Officer said that the trust had to look at the use of agency staff and other ways of working. It would take time to drive the changes.

19/091.39 Dr Carter commented on the disparity between the result of the staff survey and the remarks staff made to him. He reiterated the need to ensure good uptake of the next staff survey.

19/091.40 *Sustainable*

19/091.43 The Director of Finance remarked that the overall position was on

plan. The Trust was over performing on activity but there were shortfalls in other areas including CIPs, CQUINS and the medical staffing pay bill.

19/092 19/092.1 **Finance and Performance Committee Report to Board**

19/092.2 Mrs McConnell presented the report on the meeting of the Finance and Performance Committee which was held on 31 July. She highlighted a number of factors.

19/092.3 She reported that since the deep dive on outpatients, she had met with the team and they had already made constructive changes to the action plan. She noted that the FPC would continue to consider the pay bill position.

19/093 **Quality and Safety Committee Report to Board**

19/093.1 The Board received the Report on the meeting of the Quality and Safety Committee meeting held on 30 July 2019.

19/093.2 Dr Carter commented on the terrific presentation from the perinatal team and commented that it was fortunate that the Trust had such good staff. He also commented on progress with the fire safety plan. It was clear that a huge amount of work had been done and still more work was ongoing.

19/094 **Complaints, PALS and Patient Experience Annual Report**

19/094.1 The Director of Nursing presented the Trust's Patient Experience Annual Report for 2018 -19 including patient experience feedback, complaints and PALS activity and actions to improve patient experience.

19/094.2 She highlighted the following:

<u>Volunteers</u>:

- The Trust was fortunate to have more than 600 volunteers;
- The Butterfly Volunteers supported patients who were in the last days of their lives;
- Two community groups produced sewn and knitted goods for hospital patients.

19/094.3 <u>Dementia support:</u>

- Hannah Gardner, the Admiral nurse had been working to provide specialist dementia support to families.

<u>Carers</u>

- Jodie Deards, Carers lead, increased carer awareness within the Trust.
- The Trust continued to support carers within the Trust by *inter alia* providing snack bags for them.

19/094.4 <u>Catering:</u>

- In response to patient feedback, the Catering Team had changed the patient menu to remove unpopular items and to reflect seasonal changes.

19/095 **Infection Prevention and Control Annual Report**

19/095.1 The Director of Nursing presented the Trust's annual report in

relation to IPC. The purpose of this report was to inform and provide assurance to the Trust Board, East and North Hertfordshire Clinical Commissioning Group, patients, public and staff in regard to infection prevention and control. It provided an overview of the key work at the Trust with regard to infection prevention and control for the reporting period 1 April 2018 to 31 March 2019, and demonstrated the progress made against performance targets and compliance with the Health and Social Care Act 2008.

19/095.2 The Director of Nursing advised that 2018-19 had been a challenging year for the Trust in terms of IPC, but good progress had been made. The Trust regarded patient safety in relation to the prevention of Health Care Associated Infections (HCAI) as a key priority for the organisation.

19/095.3 Mr Niven was an active member of the Trust Infection Prevention and Control Committee who supports and contributes to the work of the Committee.

19/095.4 Last year the Trust had invited colleagues from the CCG to help with the problem around *C. Diff.* There had been a marked improvement. There was no evidence of any cross-transmission of *C.difficile* or other significant infections.

19/095.5 The Trust had a good winter with few beds closed due to outbreaks. There were no significant winter viral outbreaks which impacted on Trust operations.

19/095.6 Dr Carter remarked that he was surprised that there was still a problem with sharps disposal.

19/096 Responsible Officer Annual Report

19/096.1 The Medical Director gave the report. A new Head of Medical HR had been appointed to oversee the process in future.

A small cohort of temporary workers had not done their appraisals but overall performance was just above 90%.

Mrs Schroder commented that this was a vital part of the process as it provided assurance that doctors were able to perform their roles.

19/097 Audit Committee Report to Board

19/097.1 The report was taken as read.

Mr Silver commented that a number of items had been escalated from the committee, including in regard to the Trust's sustainability plans.

19/098 Annual Audit Letter

19/098.1 The Board noted the report which was previously considered by the Audit Committee.

19/099 Board Assurance Framework

19/099.1 In July 2019 the FPC requested a review of the IM&T risk and challenged the level of the risk rating. The Chief Information Officer and Associate Director of Corporate Governance have reviewed the principle risk, content and risk rating. The current risk rating for IM&T has been reduced from 20 to 16. The Board were asked to consider

and approved the revised risk, which they did.

19/099.2 In July, the risk in regard to MVCC had been reduced to 12. Mrs Schroder suggested that this change should be reversed and potentially restated at a higher level. The Associate Director of Corporate Governance said that she would review the risk.

19/099.3 The Board noted the latest BAF.

19/100 Annual Cycle 2019/20

19/100.1 The Board noted the Annual Cycle 2019/20.

19/101 Matters Arising and Actions Log

19/101.1 The Board reviewed and noted the Actions Log.

19/0102 Data Pack

19/102.1 The Board noted the data pack.

19/103 Date of Next Meeting

19/103.1 6 November 2019, Hertford County Hospital (11:00).

There being no further business the Chair closed the meeting at 13.10.

_____

Ellen Schroder
Trust Chair
November 2019

East and North Hertfordshire NHS Trust

Chief Executive's Report

November 2019

---

1. Pre-Election Period

On 30 October Parliament passed the Early Parliamentary General Election Bill, which amended the Fixed Term Parliament Act to hold a General Election 12 December 2019.

In light of this attached to this report is a briefing from NHS Providers which sets out considerations for NHS foundation trusts and trusts in the period of time leading up to the 2019 General Election. Official guidance and dates are yet to be confirmed, so this is based on what we expect, and we will update the briefing if anything changes.

The briefing highlights the practical implications around provider activities and communication during the pre-election period.

The briefing also considers the requirements on central and local government, the civil service and arm's length bodies during purdah to maintain political impartiality in carrying out their public duties.

We will be issuing guidance to all Trust employees during this week reminding them of their responsibilities at this time.

Board members will note that the Trust has to decide whether to allow visits by official candidates, essentially working on the basis that either all visit requests are accommodated or none, within the overriding obligation to ensure that patient care is not compounded.

At past elections the Trust has accommodated requests for visits and it is my recommendation that we should do so again at this election.

New QEII Urgent Care Centre Decision Delayed

East and North Hertfordshire CCG has decided to delay any decision to close the New QEII urgent care centre (UCC) overnight.

At the CCG board meeting, which was held in public in Welwyn Garden City, board members decided to wait until after 31 March 2020 to review the situation. This would allow time for an extensive public communications campaign to raise awareness on which services were available at the UCC overnight – after which overnight usage would be measured again.

We will of course work closely with our staff and the CCG to deliver this campaign.

2. Our Staff

Optometry Visit

We are proud to welcome optometry students from the University of Hertfordshire for the first time. Thirty third-year undergraduate students will rotate through various eye clinics at the Lister and New QEII over the next 10 weeks to gain a better understanding of different eye conditions. We are working in partnership with University of Hertfordshire for the benefit of staff, patients and students.

Safer Staffing Team Collects National Award

Congratulations are due to the safer staffing team who have won a national Allocate Award. The team came top in the Innovative workforce models for better patient care category.

They were recognised for setting up the rapid response initiative – a central staffing hub with oversight of the whole trust's staffing position, using SafeCare.

New University Role for Dr Shahid Khan

I would like to congratulate Dr Shahid Khan who has been appointed Academic Medical Lead and Visiting Professor at the University of Hertfordshire.

Shahid has worked at the trust since 1996 and is currently Director of Medical Education and Associate Medical Director – he will continue in these roles along with his clinical commitments in elderly care. Shahid's appointment will help strengthen the educational links between the trust and the University of Hertfordshire.

Joy for Joyce after winning Parents' Choice Award

Congratulations to Joyce Presland, neonatal nurse who won a Parents' Choice Award from Bliss, the UK's leading charity for babies born premature or sick. Joyce was nominated by a patient, whose baby was eight weeks premature, weighing only 2lb 11oz. Joyce was praised for the support and encouragement she gave to both parents to be fully involved in their daughter's care and helped to ease any anxiety about their child's condition.

Trust Highly Commended in National Diabetes Awards

We are delighted to announce that we have been recognised at a national diabetes award. Our initiative "Supporting Primary Care with Diabetes and Chronic Kidney Disease Management" was highly commended at the 2019 Quality in Care (QiC) Diabetes Awards, held last week.

Judges said that our entry was "an excellent example of a population health management approach, showing an innovative method to targeting" and were keen to share and spread the learning from the initiative.

UNICEF Accreditation Process Delivers Outstanding Feedback to our Maternity Team

Well done to Lister's maternity and neonatal teams for receiving outstanding feedback on their UNICEF Baby Friendly Initiative. UNICEF looks at the support given to parents to help them build close and loving relationships with their babies and to feed them in ways which will support their health and development.

The team will have to wait a little longer to find out if they have achieved their accreditation, but the feedback so far has been incredibly positive and is a fantastic achievement in itself.

Staff Awards

We have had a tremendous response to this year's Staff Awards supported by the Trust's Charity. The shortlist for this year's staff awards has been announced and I would like to congratulate all those individuals and teams who have been shortlisted for an award. The awards take place at Tewin Bury Farm on Friday 29 November.

The categories for this year are:

- Above & Beyond Award
- Bright Sparks Award
- Charity Champion
- Clinical Team of the Year
- Compassionate Care Award
- Experience Counts Award
- Here to Help Volunteers Award
- Unsung Heroes - Non Clinical Team Award
- Patients First Quality Award
- Public Nomination Award
- Safety First Award
- Team Leader Award

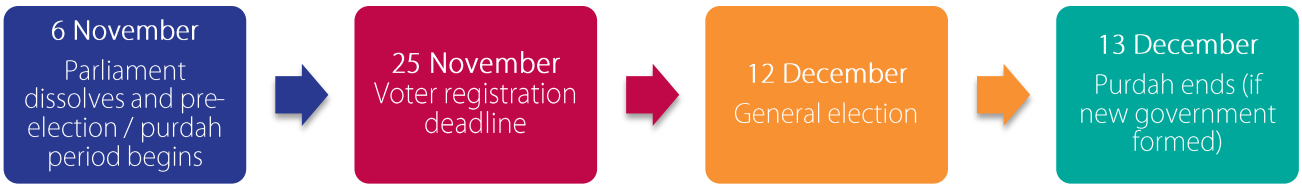
2019 General Election: pre election period considerations for NHS trusts and foundation trusts

This briefing sets out considerations for NHS foundation trusts and trusts in the period of time known as the pre-election period or 'purdah' leading up to the 2019 UK general election on 12 December. It also covers the requirements on central and local government, the civil service and arm's length bodies during purdah to maintain political impartiality in carrying out their public duties and ensuring that public resources are not used for the purposes of political parties or campaign groups.

We suggest NHS foundation trusts and trusts share this briefing and/or its specific pre-election planning with all staff and stakeholders who may find it useful to be aware of the steps you are taking.

Should you have any questions, please contact John Coutts (john.coutts@nhsproviders.org) if your query relates organisational governance or foundation trust governors, or Kerry Racher (kerry.racher@nhsproviders.org) for all other queries.

1. General election timetable



2. What is purdah?

The term 'purdah' is used across central and local governments to describe the period of time immediately before elections or referendums when specific restrictions on the activity of civil servants and local government officials, where appropriate, are in place. The term pre-election period is also used synonymously with purdah. Purdah prevents announcements from and activities by public bodies which could influence or be seen to influence the election. Purdah officially applies until the day following the general election, but effectively applies during any period of negotiation around the formation of a government. So if no party gets an overall majority, purdah restrictions remain in place until a government is formed.

3. Rules and regulations covering this period

3.1 For the government

The Cabinet Office issues guidance for civil servants in UK departments on their role and conduct during election campaigns. The 2019 guidance is expected to be available shortly on the Cabinet Office website, but the 2017 guidance sets out general principles:

- "The government retains its responsibility to govern, and ministers remain in charge of their departments. Essential business must be carried on. However, it is customary for ministers to observe discretion in initiating any new action of a continuing or long-term character."
- "Decisions on matters of policy on which a new government might be expected to want the opportunity to take a different view from the present government should be postponed until after the election, provided that such postponement would not be detrimental to the national interest or wasteful of public money."
- Civil servants should answer constituency correspondence from former MPs, avoiding individual cases becoming party political issues.
- Special advisers who will be involved in the campaign must first resign their appointments.

3.2 For NHS foundation trusts and trusts

There is has been no recent official guidance for the NHS, but you might find the 2010 guidance from the Department of Health useful. The NHS is central to a general election campaign, and this means that the custom and practice of purdah will be essential for NHS providers to adopt to avoid any impression of influencing the election or its outcomes.

In addition, the Lobbying Act 2014[1] sets out new rules for how charities and other civil society organisations can campaign in the lead up to national elections. These are designed to avoid campaign activity influencing voters, directly or indirectly. If a political party adopts policies that an organisation is already campaigning for, the organisation should not publicise the party's or candidate's support and should not alter or increase its campaigning activity as a result of that support.

[1] Full title: Transparency of Lobbying, Non-party Campaigning and Trade Union Administration Act 2014

4. Practical considerations for NHS trusts and foundation trusts during the pre-election period

4.1 Key principles

- **No activity should be undertaken which could be considered politically controversial or influential**, which could compete for public attention or which could be identified with a party / candidate / designated campaign group.
- **Would you do the same for everyone?** NHS foundation trusts and trusts have discretion in their approach, but must be able to demonstrate the same approach for every political party, official candidate and designated campaign groups in order to:
  - avoid allegations of bias or pre-judging the electorate
  - ensure you will be able to form a constructive relationship with whoever wins the seat
- **The NHS may be under the media spotlight, locally and nationally.** It is advisable to have a plan in place for:
  - how the organisation will manage the purdah periods (with both its risks and its opportunities)
  - the potential for the organisation or its partners to be singled out in the media

4.2 Board meetings and normal regulation

Normal business and regulation needs to continue during the purdah period. Routine reporting to regulators and stakeholders needs to continue. Where a board discussion or sign off is required, there is no problem with holding a board meeting. Indeed, if the purdah period is extended by post-election negotiations, good governance practice would dictate that board meetings take place.

Where board meetings need to take place, the agenda should be confined to those matters that need a board decision or require board oversight. Matters of future strategy or the future deployment of resources may be construed as favouring one party over another and should be avoided.

Use of the confidential part or part 2 of the agenda to discuss matters that may be politically controversial is not recommended. Such matters should be deferred until after the purdah periods.

4.3 Publishing information and making announcements

Care should be taken not to comment on the policies of political parties or campaign groups and websites should not be updated with any information that may be considered political. The rule of thumb should be that communications activities necessary for patient safety, quality and operational delivery purposes should continue as normal, but any other activity beyond that and not required in the pre-election period should wait until after the election.

Wherever possible, information to be published about the organisation should be factual and released in advance of purdah commencing. After purdah begins, requests for new information are best handled by applying FOI rules.

Organisations should not start long-term initiatives or undertake major publicity campaigns unless time critical (such as a public health emergency), and should instead wait until after the election. Unless strictly necessary, high-level public sector appointments should not be made.

Public consultations should not be launched during purdah. Those already in progress should continue, but it is advisable to extend the period to take account of purdah and avoid public meetings and publicity. Responses received should not be commented on and no announcements should be made until after local government elections.

We would only expect civil servants to release data (such as the regulator publishing trusts' financial returns) when a precise publication date has been pre-announced.

4.4 Individual trusts under the media spotlight

The profile of the NHS – already under intense scrutiny – will increase further as an issue of public, political and media debate during purdah. Each political party will be keen to demonstrate its support for the NHS, and the threat posed by its opponents. At times during local and national campaigning, the NHS will become the issue of the day – the focus may be on a particular issue, place, policy, individual or incident. In this context, it is likely that the depth of debate about particular local instances will be lessened and potentially used as an example of a particular issue facing the NHS nationally.

Any issues that can be predicted to be of interest during the campaign should be prepared for, with relevant information available and agreed spokespeople and lines. Where possible, it is usually easiest to use information for public comment that is already publically available and can be readily referred to.

Where affected, we would advise that trusts remain neutral, refraining from any commentary and providing only factual information where necessary. Normal patient confidentiality rules apply. It is also worth considering who it would be helpful to share information with (both in advance and in the event of any issues arising) in the local health economy and other NHS and regulatory organisations.

4.5 Local system working

It is important to bear in mind that STPs / ICSs are not bodies corporate and have no legal standing or powers in their own right. Therefore, communications issued by STPs / ICSs are the responsibility of each of the constituent partners jointly and severally. Given the potential politicisation of service reconfiguration, with regards to STPs / ICSs we would advise:

- responding to requests with reference to materials already available in the public domain;

- pausing any consultations relating to STPs / ICSs, resuming them only following the formation of the new government.

4.6 Political visits and engagement

An NHS provider has the discretion to decide whether or not to allow visits by politicians during the election campaign. When considering whether to host a visit, **safety and operational considerations must come first** and previous guidance has said that campaign visits should not disrupt services or care.

In addition, the same approach must be applied to all requests from all official candidates and political parties, irrespective of their size. All requests from candidates to visit may be declined, but if they are allowed, then all requests should be accepted. If you do not plan to permit any campaign visits, it is worth considering formally advising all candidates in advance at the same time to ensure clear and consistent understanding.

Organisations may wish to engage with the prospective parliamentary candidates (PPCs) in relevant constituencies. It is important to remember that there are no MPs – care should be taken to ensure that former MPs are not treated any differently from PPCs. Again, we would recommend that all PPCs are treated in the same way and any invitations are extended to all parties. If one party makes an announcement on site, it would be advisable to ensure that all parties do so.

4.7 Foundation trust governor elections

In law, there is nothing to prevent foundation trust governor elections from taking place during the purdah period. In practice however, **it is best to avoid holding governor elections during this period if possible**.

NHS foundation trusts and trusts should avoid activities that may be seen to favour one political party or another, and given that foundation trusts have no control over what governors may say in their election statements, at hustings or elsewhere they cannot guarantee a politically neutral outcome. What might be deemed to be party political can be quite broad – outsourcing, for example, might be associated more with one party that with others. Similarly, while governor elections have for the most part not become party political events there is nothing in law to prevent them from becoming so.

We would therefore suggest that governor elections are not held during the purdah period, noting that the period only ends when a new government is formed (rather than after election day). It is therefore important not to schedule governor elections in the immediate aftermath of the general election.
For further information relating to governor elections please contact John Coutts, governance advisor: john.coutts@nhsproviders.org or 0207 304 6875.

4.8 Activism onsite or by individual staff

NHS employees are free to undertake political activism and public debate in a personal capacity. They should, however, avoid involving their organisation or creating any impression of their organisation's involvement. They are not permitted to use any official premises, equipment (including uniforms) or information they would only have access to through their work and which is not publically available. Naturally, patient confidentiality must be preserved at all times and normal professional conduct and contractual rules apply as usual in this respect.

Especially given the prevalence of social media and the balancing act people perform in presenting their personal and professional lives and views, it becomes easier to blur or mistake the capacity within which individuals are contributing online. At all times every effort should be made to preserve public professional neutrality while not inhibiting personal activity.

4.9 Voter registration, postal votes and proxy votes

It might be helpful to advise staff on the trust's provisions for postal and proxy voting to support those – both staff, patients, service users and their families – who may not be able to go to their polling station on the day. National advice is available here: https://www.gov.uk/register-to-vote.

We would advise that **NHS staff and trusts should not undertake any voter registration or proxy or postal voting activity for those in their care** to avoid any possible concern being raised about inappropriate influence.

4.10 Trade union activities and engagement

Trade unions may be active during the election campaigning on issues concerning their members. All organisations will have existing relationships, channels and protocols for working effectively with trade unions and these should be used as normal. Nevertheless, given the importance of NHS organisations preserving their neutrality, **it is worth considering itemising the general election for discussion at an imminent meeting**.

East and North Hertfordshire NHS Trust

Agenda Item: 7

TRUST BOARD - PUBLIC SESSION – 6 NOVEMBER 2019

DIVISIONAL REPORTING OF CLINICAL STRATEGY PRIORITIES – Q2

Purpose of report and executive summary (250 words max): Following approval of the Trust's new clinical strategy (2019 – 2024), to provide the report to the Trust Board on progress made in Q2 of 2019/20.		
Action required: For discussion		
Previously considered by: **N/A**		
Director: **Director of Strategy**	**Presented by:** **Director of Strategy**	**Author:** **Head of Business Development**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) **No**
Any other risk issues (quality, safety, financial, HR, legal, equality): **No**

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

DIVISIONAL REPORTING OF CLINICAL STRATEGY PRIORITIES – Q2

TRUST BOARD - PUBLIC SESSION – 6th November 2019

1) Purpose

The purpose of this paper is to update Trust Board on the progress made by divisions and key issues being identified to support delivery of their Clinical Strategic Priorities throughout the five years of the strategy, 2019-2020. This report covers progress made in Q2 of 2019/20.

2) Background

Following approval of the Trust's Clinical Strategy (2019 – 2024) by the Trust Board in January 2019, the Board were keen to ensure that each Division quickly embedded their strategic priorities into business as usual activity and that a mechanism was put in place to ensure robust internal oversight and assurance on the progress being made, together with an understanding of particular successes and challenges.

The new strategy commenced on 1st April 2019. The Strategic Programme Board subsequently agreed an assurance reporting proposal that encompasses divisional progress reporting on a quarterly basis to the Strategic Development Committee and Trust Board, complemented by a rolling programme of divisional deep dives.

The progress report template has been designed to be simple to complete to avoid the creation of an onerous task for divisions. It gives an initial overview of progress against each clinical strategic priority and then a short update against each key action, including progress to date, any risks to delivery and issues to escalate for support.

3) Q2 Progress

Each division's report is attached in Appendix 1. Some priorities have commenced in year 1, with a one-year timespan, whilst others may have a 3-4 year timespan, or not commence until later years. This is identified on the reporting template.

The Trust's clinical strategy was informed by a comprehensive strategic case for change spanning internal and external drivers, the new strategy was then used to inform the organisation's commissioning intentions and operating plan for 2019/20 and again has been used for 2020/21. Due to the extent of clinical engagement in the development phase and careful consideration given by divisions in the final planning phase, there has generally been good initial progress.

Clinical strategy priorities align with work being undertaken across the local system and/or STP as well as internally including the development of the Local Maternity System to drive quality improvements in maternity care, the introduction of same day emergency care in August 2019 to drive further reductions in length of stay to support emergency flow, significant work to transform the way the organisation utilises its operating theatre capacity, the development of a pan STP vascular surgery network , redesign of outpatient pathways to support achievement of shorter cancer waiting times for patients and the introduction of virtual fracture clinics in September 2019

to support improved patent experience and service efficiency. Others are more specific to a division, for the Cancer Division, their strategic priority *"To secure a long term, sustainable, future for the Mount Vernon Cancer Centre"* is now being supported through the NHSE Specialised Commissioner's strategic review of the Mount Vernon Cancer Centre that commenced earlier this year and which helping to develop a strong, long term vision for services provided by the cancer centre.

4) Key Issues

Alongside reporting progress, divisions have also identified areas where they require further support to resolve key risks or enablers. Divisions are being supported to work through these and key pieces of work, for example the medical take project or Local Maternity Service objectives and funding are discussed with the executive team as part of divisional Accountability Review Meetings. Key issues that have been identified by divisions to highlight to the Trust Board are summarised in Appendix 1. These primarily fall into two broad categories; access to funding for planned service investments, particularly medical equipment, and workforce engagement, recruitment and transformation. Additionally, discussions with divisional leadership teams have highlighted the challenges they face in some areas releasing sufficient capacity to drive delivery of strategic priorities.

These issues are recognised by the Executive Team and are being addressed in a range of ways including through the Long Term Financial Strategy, People Strategy, the planned operational restructure which has been designed to enhance clinical and managerial capacity and capability within divisions and the development of an improvement approach within the organisation to support divisions to sustainably transform clinical pathways and services. The final enabling strategy to be developed to support delivery of the Trust's strategic priorities is the Estates Strategy which is expected to be completed by the end of the year following the commencement of a new Director of Estates.

5) Forward Look

As part of the Trust's annual planning cycle, work will take place over Quarter 3 to identify material changes in strategic drivers and confirm and refresh Year 2 clinical strategy objectives to enable the organisation to respond to these. This work is scheduled to be presented to the Strategy Committee in January 2020.

Key drivers that will be included in this refresh will include the STP Long Term Plan, ICP clinical priorities, recommendations from the Mount Vernon Cancer Centre Strategic Review, 2019/20 activity, performance and quality, the long term financial strategy and learning from the first year of strategy implementation.

6) Recommendations

Trust Board is asked to:

- note the progress made by divisions against their strategic clinical priorities for Quarter 2, key issues highlighted and how these are being supported.
- note that the Medicine Division will attend the private section of the Trust Board meeting to provide a “deep dive” into their clinical strategy and progress.
- Note that as part of the Trust’s annual planning cycle, work will take place over Quarter 3 to identify material changes in strategic drivers and confirm and refresh Year 2 clinical strategy objectives .

Appendix 1: Q2 2019/20 Clinical Strategy delivery – key issues identified by divisions

Division	Strategic Clinical Priority	Items to note
Cancer	To secure a long term, sustainable, future for the Mount Vernon Cancer Centre	Dedicated resource will be required to deliver Clinical Advisory Group recommendations – discussions being held with NHSI/E.
Cancer	Deliver sustained improvement of patients' experiences of the Trust's cancer services including improving access to radiotherapy to meet the needs of the population we serve	Escalation of concerns from Hillingdon and Hertfordshire health scrutiny, and national media attention on the future of MVCC has resulted in an increase in patient concerns particularly around infrastructure and In-patient care. These are being responded to through communications and engagement.
Cancer	Become the Regional Centre for Excellence in Radiation Services (to include Immunotherapies, Nuclear Medicine, Radiation Protection and Aseptic Services)	Recognised as regional experts in a number of areas. However our ability to ensure sustainability and deliver further growth is part of the scope of the commissioner led MVCC review. Capital is required to support the replacement of LA1 and Spec-CT.
CSS	Develop a radiology strategy and enabling funding strategy to ensure appropriate capacity to sustainably meet demand, by critically assessing working arrangements, capital requirements, technological solutions, existing physical capacity and future demand drivers.	Significant dependency on access to capital Need to transform radiology workforce and service to attract and retain skills and capacity required
W&C	Achieve an outstanding CQC rating for our services by transforming services in line with National Ambitions and Drivers to improve outcomes	Non-recurrent funding from Local Maternity System (LMS) – division to put plan in place to mitigate associated risks if replacement funding streams are not identified.
W&C	Deliver consistent, high quality care and ensure patients receive the most appropriate care for their condition, from those most clinically appropriate to deliver it, and in the most appropriate setting	Non-recurrent funding from Local Maternity System (LMS) – division to put plan in place to mitigate the associated risks if replacement funding streams are not identified.
Medicine	Provide consistently high quality urgent and emergency care by : a) reviewing and revising the medical inpatient model to ensure that every patient is admitted under the care of the most clinically appropriate specialty with inter-specialty support as required; b) optimising the use of ambulatory and outpatient models of care to avoid unnecessary hospital admissions and enable patients to be cared for in their homes	Medical take project proposals in development currently and will be piloted as part of our winter plan Dec-March. This will deliver additional specially consultant capacity at the front and earlier medical outlier ward rounds Key risk – recruitment of acute medics and specialty clinical leadership. Workforce supporting the division with recruitment.

Medicine	Work collaboratively with system wide partners within the STP to promote self-care and to ensure standardised pathways for the management of long term conditions to help reduce emergency attendance, with a particular focus on: • Frailty • Diabetes • Respiratory	Extension to frailty assessment to increase provision to 70 hours is in progress but will require alternative staffing model for weekends due to recruitment challenges for both medical and nursing posts. Risk to full delivery of weekend cover

7) Appendix 1: Divisions' Q2 progress on Strategic Clinical Priorities

Cancer Division's Strategic Clinical Priorities Highlight Report
Reporting Period: Quarter 2

No.	STRATEGIC CLINICAL PRIORITY	OVERALL CONFIDENCE RATING	Progress vs 2019/20 plan	Risks	Items to note / for discussion	Items to escalate? Y/N
1.	To secure a long term, sustainable, future for the Mount Vernon Cancer Centre	⇔	⇔	⇔	Specialist commissioner led MVCC review in progress – short term action plan objective 3 funding approved for the recruitment of AOS nurses and consultant, however still awaiting approval of funding for a ward consultant.	Y Dedicated resource required to deliver Advisory Group recommendations
2.	Deliver sustained improvement of patients' experiences of the Trust's cancer services including improving access to radiotherapy to meet the needs of the population we serve	⇔	⇔	⇔	Escalation of concerns from Hillingdon and Hertfordshire health scrutiny, and national media attention on the future of MVCC has resulted in an increase in patient concerns particularly around infrastructure and In-patient care.	Y
3.	Improve patient outcomes by facilitating earlier diagnosis and timely, effective treatment and support - own complete cancer pathways end to end for Breast, Urology, Lung and Colorectal (from diagnosis; living with and beyond cancer; supporting and managing End of Life)	⇔	⇔	⇔	Elements of cancer business case in delivery. FITT testing for early diagnosis of colo-rectal cancer in progress.	N
4.	Establish strategic partnerships to maximise commercial opportunities for long term sustainability and better patient outcomes	⇔	⇔	⇔	Baxter awarded dose banded tender. Refurbishment of Lister aseptic unit in progress.	N
5.	Become the Regional Centre for Excellence in Radiation Services (to include Immunotherapies, Nuclear Medicine, Radiation Protection and Aseptic Services)	⇔	⇔	⇔	Recognised as regional experts in a number of areas. However our ability to ensure sustainability and deliver further growth is part of the scope of the commissioner led MVCC review. Capital is required to support the replacement of LA1 and Spec-CT.	Y

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
To secure a long term, sustainable, future for the Mount Vernon Cancer Centre			To develop a response to NHSE's Modernising Radiotherapy Services in England. Work with partners to develop a networked radiotherapy service that meets Commissioner's specifications.	Response developed		Divisional Chair, Cancer	Exec and clinical presence at RT network oversight meetings. TOR and work plans approved. Good clinical engagement.	
			To optimise benefits for MVCC of its clinical and academic collaboration with UCLH	Project plan		Hospital Director / Divisional Chair/ clinical director /Head of Nursing	Year 2 objectives agreed. Aligned to the MVCC strategic review objectives. Medical teams to coordinate tumour specific academic meetings. Breast meeting scheduled for September 2019. Melanoma joint team approach is in delivery.	Ensure each of the 4 solid tumour teams schedule a joint academic meeting in 2019/20. No further progress of year 2 objectives, until expressions of interest / tender process of ownership has been agreed by commissioners.
			Secure the Cancer Centre's medium-term tenure of the Mount Vernon site and work with the landlord to improve the environment within which cancer services are provided	Plan in place, including estates improvement plan		ENH Exec team	Recommendation 5 of the MVCC strategic review, short term action plan requires completion of "back log maintenance." Fortnightly joint estates meetings reconvened with HHT.	Need to ensure ENHT head of estates input.
			Work with Michael Sobell Charity and stakeholders to agree and implement a future model of End of Life care that meets the community's needs	Plan in place and being implemented		COO / ENHCCG	Formal handover of Out-patient and In-patient care is still in progress. However, Hayes and Harlington have been named as the new provider, and building contractors have started repair works of the In-patient facilities.	HHT transition costs identified. Concern that there will be a further delay in handover of services. Staff anxiety and progress has been slow.

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Deliver sustained improvement in patients' experience of Trust cancer services including improving access to radiotherapy to meet the needs of the population we serve.			Understand key drivers of patient experience and engage patients in the development and delivery of a programme to deliver sustained improvement.	Patient Experience Surveys and feedback		Head of Engagement: Specialist commissioners Head of Engagement ENHT	4 engagement events scheduled for July as part of stakeholder involvement in shaping the future of MVCC. Patient story presented to Trust Board in July As part of the future planning of systemic therapy provision, the division has been working with BMS. 2 local patient experience sessions completed in Lung and melanoma pathways. Action plans in delivery	
			To develop a response to NHSE's Modernising Radiotherapy Services in England. Work with partners to develop networked radiotherapy services, that meets Commissioner's specifications	Response developed		Divisional Chair, Cancer	Exec and clinical presence at RT network oversight meetings. TOR and work plans approved. Good clinical engagement.	
			Write and implement the business case for a satellite radiotherapy unit in Stevenage.	Business plan in place			This will be taken forward as part of the specialist commissioner led review of the future service model for MVCC.	Sustainability of the existing service will take priority before an expansion of the existing service can be considered.
			Work with STP partners to develop and deliver an integrated and streamlined pathway for cancer patients from initial diagnosis through to end of life planning.	Plan in place		Head of Strategy, ENHT	Implementation of 28 day faster diagnosis standard in progress.	PET-CT capacity due to the delays in national team awarding the PET-CT tender. (Joint tender between In

												Health / PSSC). Diagnostic pathways are included in tumour specific RAPs and monitored through cancer board.
			Work with STP partners to develop and implement risk stratified follow up and support pathways for patients including the effective transfer of patients ongoing care into the community setting	Pathways in place						Hospital Director / Divisional Chair/ Head of Nursing	Stratified pathway project lead appointed to support delivery of stratified pathways in breast and urology follow up care.	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Improve patient outcomes by facilitating earlier diagnosis and timely, effective treatment and support - own complete cancer pathways end to end for Breast, Urology, Lung and Colorectal (from diagnosis; living with and beyond cancer; supporting and managing End of Life)			Work with other specialities to implement best practice, timed pathways and deliver national cancer standards	Implementation of timed pathways Achievement of national cancer standards		Hospital Director	Did not meet the recovery trajectory in October 2019. Dr Nikhil Vasdev (NV) appointed as Associate director for cancer, to support clinical engagement and delivery of improved cancer performance.	Pathology and CSS RAPs monitored via monthly cancer board.
			From both a clinical and financial perspective have assessed owning the whole pathway for the four solid tumours, skin/melanoma across all sites, and rare cancer	Assessment undertaken		Hospital Director / Divisional Chair/ clinical director / Head of Nursing	Expert advisory panel findings presented to MVCC strategic development project board, defining the 2 preferred options.	
			Have a plan agreed with commissioners and partners for the identified services we do not want to own end to end	Plan agreed		Head of Strategy, ENHT		The wider MVCC strategic review recommends no changes to patient pathways during the interim phase of the project.
			Identified appropriate means to manage our chosen end to end pathways, e.g. in partnership for particular elements	Plan in place			From Year 2	
			Identified the optimal location and environment for services, e.g. co-location with surgery and anaesthetics, inpatients and specialist diagnostics to maximise quality, patient experience and access	Plan in place			From Year 4	
			Support delivery and sustainability of all eight waiting time standards for cancer, including the 62 day referral-to-treatment cancer standard.	Waiting time standards being met		Hospital Director	Did not meet the October recovery trajectory by 1 %.	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Improve patient outcomes by facilitating earlier diagnosis and timely, effective treatment and support - own complete cancer pathways end to end for Breast, Urology, Lung and Colorectal (from diagnosis; living with and beyond cancer; supporting and managing End of Life) (CONT)			Make the current Mount Vernon site fit for purpose, particularly Nuclear Medicine, OPD and ward areas	Present options appraisal to include local redevelopment or alternative solutions		Hospital Director / Divisional Chair/ clinical director / HoN	Expert advisory panel findings presented to MVCC strategic development project board, defining the 2 preferred options.	Preferred provider to be identified. Access to capital to put these options into delivery
			Ensure the whole cancer centre meets all mandatory and statutory requirements for excellent cancer services to include CHKS, IRMER, ARSAC and a 'Good' CQC rating			Hospital Director / Divisional Chair/ clinical director / Head of Nursing	CHKS accreditation of ISO 9000 standard. CQC report expected this month. Quality review of In-patient care on 7/11/19 requested by NHSE due to escalation of concerns.	The uncertainty of the future of MVCC's and risks associated with sustainability may influence the findings of CQC. In-patient care is flagged as high risk.
			In conjunction with other providers in the STP support the rollout of FIT in the bowel cancer screening programme and the IT infrastructure to support movement of stratified pathways for breast	Roll out complete			From Year 2	
			Continue to grow ENHT rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers, ensuring that patients get timely access to the latest diagnosis and treatment	Pathways reviewed and changes implemented			From Year 2	
			Strengthen the academic research portfolio for our chosen tumour pathways, including clinical trials	Research culture embedded; research and trials increased			Overall increase in patients recruited into trials, and new trials opened. Continue to strength the rel with UCLH.	
			Introduce nurse and pharmacist led prescribing to improve / increase capacity	Patient satisfaction, complication management, service availability and accessibility			2 ACPs and 2 prescribing pharmacists. Each with	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Establish strategic partnerships to maximise commercial opportunities for long term sustainability and better patient outcomes			Establish partnerships to provide a specialist manufacturing service from the Lister Pharmacy Aseptic Unit for specialist chemotherapy, trial drugs and novel substances to other organisations across the STP and beyond	Potential partners identified, assessment undertaken and partnership established		Head of Business Development	Refurbishment of Lister Aseptic Unit in progress. Baxter successfully awarded dose banded tender for MVCC.	
			Work with BMI at MVCC to develop a private cancer referral pathway on site	Private cancer referral pathway established and running successfully		Hospital Director	Early discussions. However the service has continued to expand Private Patient activity therefore, no further discussions with BMI are necessary at present.	Request for approval to close this action.
			Explore opportunities to link with companies to commercially provide patient specific devices made in biomedical engineering	Plan in place			From Year 2	
			Establish a Clinical Trials Unit.	Plan in place; clinical trials unit established			From Year 2	
			Explore option for partnering with commercial producer of PET radiopharmaceuticals with the ability to produce PET radiopharmaceuticals using radionuclide generators on site e.g. Production and supply of Ga68 for PET cancer imaging to PSSC and other PET imaging providers within a 1 to 1.5 hour travel radius from site	Potential partners identified, assessment undertaken and partnership established			From Year 2	
			Redesign the chemotherapy authorisation	Pathway		Head of	Completed for	

			and procurement pathway in order to secure a reliable, responsive and sustainable source of aseptic chemotherapy doses	redesigned and reliable source in place						Nursing / Senior Site Manager and Business Management Pharmacist	both LMC and MVCC	
			Develop strategic partnerships with commercial aseptic units in order to introduce a “managed inventory model” for ready to use and dose banded chemotherapy	Potential partners identified, assessment undertaken and partnership established							From Year 2	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Become the Regional Centre for Excellence in Specialist Services (to include Immunotherapies, Nuclear Medicine, Radiation Protection and Aseptic Services)			Provision of a centralised radiopharmacy services to a larger number of customers (as per DoH /BNMS guidance) to explore opportunities to acquire services from other smaller providers e.g. Northwick Park	Plan in place			From Year 3	
			Fundraise for SPECT/CT, possibly in conjunction with charitable partners. To ensure that the cancer centre has state of the art imaging capability and can provide radiation dosimetry for all radionuclide therapies (as per new IRMER regulations)	Plan in place		Hospital Director	Awaiting confirmation from ENH charity lead to progress with fundraising appeal	
			Support and manufacture theranostics for cancer treatment	Plan in place			From Year 2	
			Engage with providers of nuclear medicine training programs / apprenticeship schemes for healthcare scientists and practitioners to ensure adequate workforce for the future	Plan in place		Hospital Director	NHSi lead identified working with respective service leads to develop a 5 year workforce plan.	
			Discuss with breast / plastic surgeons the introduction and repatriation of sentinel node imaging for breast and melanoma in line with NICE Guidance	Plan in place		Hospital Director	Radiology training completed. Equipment ordered. Awaiting completion of radiopharmacy upgrade; scheme can then progress to delivery	
			Obtain MHRA Manufacturers Investigational Medicinal Products (IMP) Licence to produce and supply novel diagnostic and therapeutic radiopharmaceuticals for use in research trials at MVCC and other organisations	Plan in place; licence obtained			From Year 3	

Clinical Support Services Division's Strategic Clinical Priorities Highlight Report
Reporting Period: Quarter 2

No.	STRATEGIC CLINICAL PRIORITY	OVERALL CONFIDENCE RATING	Progress vs 2019/20 plan	Risks	Items to note / for discussion	Items to escalate? Y/N
1.	Deliver a better patient experience by seeking to undertake all diagnostics only once, unless clinically indicated otherwise, working with primary care to ensure easy sharing of results across the health system.	⇔	⇔	⇔	• Phase 1 of order comms ICE upgrade completed • Outpatient Board implemented	N
2.	Develop a radiology strategy and enabling funding strategy to ensure appropriate capacity to sustainably meet demand, by critically assessing working arrangements, capital requirements, technological solutions, existing physical capacity and future demand drivers.	⇔	⇔	⇔	• HCH Plain film and MRI refurbishment delivered • Wave 5 plans being developed to support Radiology imaging bid • Capital constraints and national radiology workforce challenges remain a risk • remain a risk	Significant dependency on access to capital Need to transform radiology workforce and service to attract and retain skills and capacity required

3.	Deliver the pharmacy transformation programme, securing high quality services, to enable effective patient flow through wards and clinics.	⇦	⇦	⇦	• Roll out of Ward based Pharmacy to 9 wards • 16 NMP Pharmacists in post including 4 at MVCC (6 pharmacists in training) • Secured capital funding to refurbish Lister Aseptics • Refurbishment of Aseptics due to commence from the 4 November 2019 • Chemotherapy dose banding tender completed	N
4.	Ensure the future provision of high-quality, cost-effective pathology services, working collaboratively with STP partners to establish an STP pathology network.	⇦	⇦	⇦	• Playing key role in STP project • Ensuring implement lessons from TPP • Supporting colleagues through fortnightly comms • Working towards July 2020 contract award	N
5.	Work with STP partners to develop a sustainable model for Interventional Radiology across the STP which will meet Trust and STP expectations of future requirements.	⇦	⇦	⇦	• work ongoing with project team to support vascular hub and development of IR services	N

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Deliver a better patient experience by seeking to undertake all diagnostics only once, unless clinically indicated otherwise, working with primary care to ensure easy sharing of results across the health system.			Optimise and develop order-comms system to exploit opportunities for improving protocols, processes, reducing variation, improving functionality and productivity.	Plan in place; order-comms fully optimised; reduced variation		LC	Phase 1 software upgrade (ICE) delivered in May 2019 Phase 2 : now in project planning stages 20.10.2019 weekly meetings to progress work plan Speciality pages being reviewed Cost of tests now in ICE GTT booking to be made on ICE Speciality pages being reviewed NHS mail to NHS.net mails for alerts under user acceptance testing (UAT) Cost of tests now in ICE Exploring possibility of ICE-Lorenzo integration	PMO lead required
			Streamline pathways in haematology for referrals, investigations, and clinic scheduling to improve quality and ease of use for patients.	Pathway redesigned; clinic scheduling improved		NS/JH	Implemented Advice and guidance, with robust monitoring and compliance Full clinic template review now undertaken Review of cancer pathway undertaken and identified opportunities to streamline pathways 22/10/19 – CNS post offered awaiting start date	Workforce challenges-business case approved to support new ways of working including the recruitment of CNS
			Work with primary care to ensure the easy sharing of diagnostic results	Plan in place		NS	Inputting into STP interoperability workstream to support link between ENHT and primary care systems	

			Develop a model of outpatients that allows the Trust to be in the top X% of benchmarked peers in terms of productivity, to improve quality and ease of use.	Peer review						JMc	Implementation of outpatient board Introduction of two way text reminder with positive results Suite of KPI's have been worked up and approved through OP Board, next action to develop monitoring tools for KPIs 22/10/19 Reports are being created with the information team to be able to measure the approved KPI's (1 report out of 9 received) New benchmarking data has been released which demonstrates areas to focus on improvement (Oct 19) Transformation work streams have been designed to support the vast amount of transformation required.	Data quality Information/qlikview development resource
			Improve use of digital systems in line with our stabilisation programme to support service improvement and reduce wastage (for example, in bookings, records, and appointment management).	Cancelled clinics; rebooked appointments						JMc	Working with new CIO to ensure all services represented in digital strategy 22/10/19 Workshop with all stakeholders in November 19 to ensure clear aim is identified for moving digital solutions forward. Business case is being developed to roll out Liberty 5 incorporating different communication mechanisms to our patients and a patient hub. Concept has been approved at the Deputy's Forum.	Capital constraints

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Develop a radiology strategy and enabling funding strategy to ensure appropriate capacity to sustainably meet demand, by critically assessing working arrangements, capital requirements, technological solutions, existing physical capacity and future demand drivers.			Develop a radiology strategy: • Review current and predicted future demand and capacity across all services • Explore options for approach to provision • Develop preferred model for delivery and workforce • Work with STP to develop wider network elements	Assessment undertaken; preferred plans developed; strategy in place		NS/SC	D&C work undertaken with NHSI Introduction of urology one stop Carve out CT capacity provided for endoscopy to improve pathway	Need to develop STP approach to Radiology services
			Underpin service sustainability with a resourced forward plan for equipment provision and maintenance, balancing in-house (purchase or lease) with managed service options; identify capital implications to inform Trust capital programme.	Plan in place		NS/SC	2018/19 New HCH x-ray and Lister MRI refurbishment completed with charitable support Options currently being worked through to support equipment replacement plan Dental equipment has been replaced at Lister October 2019 Currently in procurement process to replace Siemens CT scanner at Lister Site visits underway for IR equipment for the new hybrid theatre	Availability of capital funding
			Write business cases for urgent short term capacity area: plain film X-Ray in ED	Business plan approved			To be included in Wave 5 submission	Availability of capital funding
			Extend access to services: 24/7 access to IR (including link to Vascular development) 7-day access for MRI	Access in place		KS SC	Working with Vascular hub project to secure robust workforce options to deliver 24/7 service and physical space to deliver our future IR service Scoping clinical pathway to support 7 day MRI, aim to present case Charities still fundraising for IR recovery area Awaiting agreement for funding from winter pressures for 7 day access to MRI	Clinical engagement across network to support rotas Awaiting approval of band 7 IR lead Radiographer post. PAH patients will be coming from December 2019 instead of the original plan of April 2020

			Identify opportunities for new roles / crossover roles in all specialties, under-pinned by training and development of staff, to reduce reliance on medical staffing and improve quality, e.g. reporting radiographers	Training plan in place; new roles identified; pipeline for training and recruitment understood and in place						NS	Job planned reporting radiographers in place, training budget allocation to support upskilling sonographers to complete more complex scanning and radiographers in administering injections. Review of associate mammography posts ongoing Reporting Radiographers recruited – 1 starting October 2019, 1 in December and 1 in January 2020. 1 Radiographer has commenced the PgD in extremity reporting October 2019 1 Radiographer due to commence mammography course November 2019 2 trainee sonographers started September 2019	National Shortage of radiographers/sonographers
			Introduce / extend home reporting for radiology	Home reporting in place						NS	Hardware delivered, with PACs upgrade due to take place in September, with full training programme and then a phased roll-out into consultants homes PACs upgrade currently scheduled November 2019	Trust IT software issues to be resolved Trust virus software may be incompatible with PACs upgrade

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Deliver the pharmacy transformation programme, securing high quality services, to enable effective patient flow through wards and clinics.			Complete tender and out-sourcing of production functions in pharmacy to secure sustainable services.	Tender complete		AH	Capital funding received to refurbish Lister aseptics (£750K) 22/10/19 Refurbishment of Aseptic due to commence from the 4 November 2019 Tender process for dose banded chemotherapy to commence from 22 July 2019 22/10/19 Completed and contract awarded to Baxter	Risks – affordability of design and timescale to deliver project
			Explore dispensing of outpatient prescriptions through partnerships with community pharmacies to release in-house capacity.	Plan in place			From year 2	
			Implementation of e-prescribing in pharmacy to deliver consistent quality and ease of use: • Secure funding and support • Implementation	E-prescribing in use		AH	The Lorenzo Investment Case (LIC) and Benefits case has been approved by NHSD An EPMA Project Board has been set up - SRO is Dr Tim Walker and the board will meet once every 2 weeks. Timescale is for EPMA to be piloted on one ward by February 2020 and then to be rolled out during 2020/21	

			Implement workforce redesign elements of Pharmacy Transformation Plan: • Roll out ward-based pharmacists across the Trust to reduce length of stay and improve medicines management. • Train 6 non-medical prescribers per year for 3 years to improve practice and release scarce medical time. • Develop PSW roles on wards to release pharmacist time. • Develop Advanced Practitioner roles • Develop specialist and integrated pharmacy roles and service across the STP.	Ward-based pharmacists on wards; training plan in place; STP options explored						AH	Ward based pharmacy has been rolled out to 9 wards 22/10/19 16 NMP Pharmacists in post including 4 at MVCC (6 pharmacists in training) A joint hospital pharmacist/PCN role has been developed. Interviews to take place in October 2019	
			Improve prescribing practice with guidance and improved management of discharge medication and prescription-only medicines (POMs).	Improvement in number of discharges without medication						AH	New Lorenzo discharge Template launched across the Trust Clear process of approval by doctor and verification by pharmacist has been introduced - action completed	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Ensure the future provision of high-quality, cost-effective pathology services, working collaboratively with STP partners to establish an STP pathology network.			Complete and implement STP review of pathology, ensuring that it is appropriately scoped and that implications for out-of-scope services are identified and addressed appropriately. (For more detail on this programme of work, refer to STP Pathology review.)	Review completed. Work commenced on procurement.		CM/TW/ SB	5 x work streams now place with ENHT well represented on all, feeding into the programme board Fortnightly staff communication process in place 20/10/2019 SOR v13 and ITPD being reviewed for sign off	Key stakeholder engagement across STP, Executive Lead Phlebotomy scope requires sign off from all trusts/CCGs No formal COMMS coming from STP COMMS Lead LTS have gone into administration; LMG has taken over, but contract novation not yet complete, ?will impact on project timeline
			Introduce / extend home reporting for radiology and pathology	Plan in place.		NS	Hardware delivered, with PACs upgrade due to take place in September, with full training programme and then a phased roll-out into consultants homes PACs upgrade currently scheduled November 2019	Trust IT software issues to be resolved Trust virus software may be incompatible with PACs upgrade
			Develop inpatient service for haematology (links to priorities in Cancer and Medicine Divisions)	Service introduced		NS	Bed space identified and meetings scheduled to review flow and job plan changes required	Workforce not sufficient to support extended role
			Develop Advanced Practitioner roles in haematology	Plan in place; new roles in staffing mix		NS	Developed JD for CNS following review of model with nursing leadership team Business case for CNS approved, post offered awaiting start date	
			Link with West Herts and Cambridge to establish rotational training grade in haematology	Discussions held; plans in place			From year 2	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Work with STP partners to develop a sustainable model for Interventional Radiology across the STP which will meet Trust and STP expectations of future requirements.			Extend access to services: • 24/7 access to IR (including link to Vascular development)	24/7 access in place		KS	Working with Vascular hub project to secure robust workforce options to deliver 24/7 service	Clinical engagement across network to support rotas
			Business cases for IR recovery area written and approved	Business case written and approved		KS/JC	Design options being work through to support 24/7 IR service Architect drawings complete and charitable funding committed in conjunction with committed spend from vascular hub	
			Identify opportunities for new roles / crossover roles in all specialties, under-pinned by training and development of staff, to reduce reliance on medical staffing and improve quality.	Opportunities identified; training plan in place		NS/JC	Job planned reporting radiographers in place, training budget allocation to support upskilling sonographers to complete more complex scanning and radiographers in administering injections. Review of associate mammography posts ongoing	National Shortage of radiographers /sonographers

Medicine Division's Strategic Clinical Priorities Highlight Report
Reporting Period: Quarter 2

No.	STRATEGIC CLINICAL PRIORITY	OVERALL CONFIDENCE RATING	Progress vs 2019/20 plan	Risks	Items to note / for discussion	Items to escalate? Y/N
1.	Provide consistently high quality urgent and emergency care by : a) reviewing and revising the medical inpatient model to ensure that every patient is admitted under the care of the most clinically appropriate specialty with inter-specialty support as required; b) optimising the use of ambulatory and outpatient models of care to avoid unnecessary hospital admissions and enable patients to be cared for in their homes				a) Medical take project proposals in development currently and will be piloted as part of our winter plan Dec-March. This will deliver additional specially consultant capacity at the front and earlier medical outlier ward rounds b) SDEC – "perfect week" to focus on SDEC and flow agreed w/c 25/11 c) Risk – recruitment of acute medics and specialty clinical leadership	Y
2.	Work collaboratively with system wide partners within the STP to promote self-care and to ensure standardised pathways for the management of long term conditions to help reduce emergency attendance, with a particular focus on: • Frailty • Diabetes • Respiratory				Extension to frailty assessment to increase provision to 70 hours is in progress but will require alternative staffing model for weekends due to recruitment challenges for both medical and nursing posts. Risk to full delivery of weekend cover	Y
3.	Deliver outpatient services effectively, improve ease of use and make best use of resources (e.g. maximising use of nurse-led clinics), introducing new models of delivery (such as telemedicine) and moving activity to primary care and self-management where clinically possible.				Division had initial discussions with all specialties about transformation of OPD services and new models, we are currently prioritising specialties for focus	N
4.	Secure sustainability by working with the STP, reducing reliance on locum staffing and finding alternatives to the medical model, through innovative staffing structures, training and development, with a particular focus on: • Elderly medicine • Dermatology/Skin Health • Neurology				Frailty -ENHT team engaged with Frailty/ageing well STP workstream. Dermatology – STP-wide review of model in progress. In the meantime, ENHT recruitment improved, now more sustainable service. Neurology – STP - limited progress	N
5.	Ensure all services are clinically and financially sustainable, working with the STP as appropriate, with rigorous focus on challenged specialties, including: • Renal • Diabetes / Endocrinology • Dermatology/Skin Health				This requires divisional focus during Q3	N

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Provide consistently high quality urgent and emergency care by : **a) reviewing and revising the medical inpatient model to ensure that every patient is admitted under the care of the most clinically appropriate specialty with inter-specialty support as required;** **b) optimising the use of ambulatory and outpatient models of care to avoid unnecessary hospital admissions and enable patients to be cared for in their homes**			**Urgent care:** Establish "Emergency Village" (as per Model Hospital) to improve quality, outcomes and patient flow: • Establish effective bed bureau to ensure bed state managed in the optimal way • Ring-fence assessment capacity to eliminate unwarranted delays in assessment and direction to appropriate service. • Maximise ambulatory care, aiming to reach X % ambulatory by 2022 • Deliver "direct to specialty" care, to provide the optimum expertise for every patient, including: o Hot clinics o Review balance of inpatient capacity to match patient need • Continue to build new pathways and embed new ways of working to secure sustainability in line with STP plans and aspirations	Emergency Village established; meeting 4 hour target; bed wait from DTA reduced; use of ambulatory care increased; hot clinics established; review completed on inpatient specialty requirement and changes made to bed allocation		SM, BS, CM	a) The transformation of inpatient care requires a significant change to the way the medical take is managed and staffed and also the engagement of the site office/bed managers. This projectis being intiated in September b) The SDEC proposals have been agreed and CCG is supportive of approach and revised tariff. Mobilisation plan currently being drafted	• Clinical engagement • Site office and bed management engagement • Workforce – new ways of working and recruitment to posts, particularly consultants in acute medicine • IT to support new models
			Extend specialty support to other specialties, including: • Elderly care input (such as that offered in the ortho-geriatrics service) to a wider range of	SOP in place for management of patients; LoS reduced; number of medical		CR&JL	Discussion with planned care colleagues ongoing. POPs consultant post currently out to advert	• Surgical engagement • Workforce – recruitment to POPs consultant post

			surgical patients. • Extending Neurology support (e.g. hot clinics to reduce unnecessary admissions) • Cardiology input to non-cardiology ward extended to 6 days.	outliers reduced					PW&CS NK&CS	Neurology and cardiology new models approved and currently out to recruitment. Plan to initiate new pathways from November/December once posts recuited to	• Long term funding for POPs.

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5					Lead	Progress to date, including successes	Risks, including support required
Work collaboratively with system wide partners within the STP to promote self-care and to ensure standardised pathways for the management of long term conditions to help reduce emergency attendance, with a particular focus on: • Frailty • Diabetes • Respiratory			Work with STP to standardise patient pathways, removing unwarranted variation, particularly in: Frailty Diabetes Respiratory Cardiology	Pathways revised and implemented; reduced LoS; reduced admissions						CDs	Frailty proposals for 70 hour provision approved and mobilisation plan being drafted.	Workforce recruitment
			Define a Divisional priority plan for extending pathways into the community, based on an assessment of each specialty's current position and potential (to avoid risk to quality of existing services).	Divisional plan written						CDs	For discussion at Divisional board to agree priority pathways	
			Pursue priority areas for pathway extension where pathway already established and ready to roll out: STP Frailty pathway Acute Kidney Injury (AKI) pathway	Frailty and AKI pathways rolled out; reduced LoS; reduced admissions						CB AF	AKI pathway embedded, 40 hours already provided, working on provision of 70 hours	
			Pursue other areas for pathway extension, as defined in above Divisional priority plan	Pathway plans in place; reduced LoS; reduced admissions							From Year 2	
			Work with system partners to co-design and optimise pathways for OPAT (outpatient antibiotic therapy), to reduce unnecessary admissions and improve quality and outcomes.	Pathway redesigned and in place; reduced admissions; better QoS						AG	OPAT audit currently underway to establish baseline and size of opportunity	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Deliver outpatient services effectively, improve ease of use and make best use of resources (e.g. maximising use of nurse-led clinics), introducing new models of delivery (such as telemedicine) and moving activity to primary care and self-management where clinically possible			Actively engage in the Outpatient Transformation Project (part of Model Hospital) to co-design models and improve ease of use, resource utilisation and quality of care.	Use of Seeker embedded in Division; review of outpatient activity demand and capacity completed			Demand and capacity work yet to be completed.	Contact Centre capacity to deliver
			Contribute to Contact Centre redesign, to ensure that all clinic scheduling is optimised to match the specific clinical needs of individual specialties.	Redesign completed			Contact centre redesign requires further review	
			Identify successful examples within the Division of new models, including virtual clinics and telemedicine, and use lessons learned to extend elsewhere (for example, virtual fracture clinic in ED).	Plan in place			Diabetes proposal with execs. Cardiology have developed a proposal for virtual clinics, awaiting approval. Specialty Transformation workshops established in September for further discussion	
			Work with STP Planned Care workstream re. provision of and appropriate use of advice and guidance, both telephone and letter, and moving activity to primary care and self-management where clinically possible	Plan in place; use of advice and guidance increased with corresponding decrease in referrals				
			Extend the range of multi-disciplinary outpatient clinics, including “one-stop shops” to improve ease of use.	Number of multi-disciplinary clinics increased; reduced internal referrals			Part of workshop to identify new opportunities	

Clinical Priority	RAG Previous period	Rag This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Secure sustainability by working with the STP, reducing reliance on locum staffing and finding alternatives to the medical model, through innovative staffing structures, training and development, with a particular focus on: • Elderly medicine • Dermatology /Skin Health • Neurology			Identify new medical staffing model to deliver Emergency Village (see Objective 1); explore alternative approaches to junior and middle grade staffing (e.g. Physician Assistants in elderly medicine, training posts / MTIs in stroke services).	New staffing models identified for use in each specialty			Workforce plan for new model requires further ACPs, consultant and nursing posts.	
			Develop workforce planning tools to allow a more sensitive matching of staffing with workload	Planning tools developed			From Year 4	
			Map current non-medical workforce and identify opportunities for new roles / crossover roles, under-pinned by training and development of staff, to reduce reliance on scarce medical staffing and improve quality. Examples may include extending the use of: • Specialist Nurse roles in Neurology (MS and epilepsy) • Specialist Nurse roles in Rheumatology • Specialist Nurse roles in Elderly Medicine • ACPs in ED	Mapping completed; plans in place for recruitment of alternative staffing roles			New lead ACP post appointed to take forward development of this key workforce. Once D&C activity modelling complete, we will agree workforce required to deliver revised pathways.	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Ensure all services are clinically and financially sustainable, working with the STP as appropriate, with rigorous focus on challenged specialties, including: • Renal • Diabetes / Endocrinology • Dermatology /Skin Health			Swift resolution of future for Dermatology / Skin Health – either STP solution or link with Plastics	Plan in place			Ongoing discussion at STP	
			Develop a sustainable model for Renal services across the main Trust sites and satellite locations.	Model in place				
			Develop strategic partnerships in order to strengthen the overall sustainability of, and local access to, cardiology services within the STP.	Improved local accessibility to cardiology service within STP			New partnership being developed with Barts	
			Address clinical sustainability issues in acute medicine through Emergency Village development (see objective 1)	Acute medicine assessed as clinically sustainable			Workforce a key enabler, particularly ACPs and acute consultants	
			Address clinical sustainability issues in Elderly care through workforce initiatives (see objective 4)	Elderly care assessed as clinically sustainable			Development of frailty workforce – ACPs and consultants	
			Address financial sustainability issues in challenged specialties – current analysis suggests these include Diabetes / Endocrinology, Elderly Medicine and Rheumatology	Contribution %				
			Review progress with delivering GIRFT recommendations. Develop, agree and deliver plan to implement remaining actions to optimise expected benefits.	Plan in place and being delivered			GIRFT action plans being developed for specialties that have had a review	

Surgical Division's Strategic Clinical Priorities Highlight Report
Reporting Period: Quarter 2

No.	STRATEGIC CLINICAL PRIORITY	OVERALL CONFIDENCE RATING	Progress vs 2019/20 plan	Risks	Items to note / for discussion	Items to escalate? Y/N
1.	Consistently deliver high quality, compassionate care across all services.	⇧	⇔	⇔	NATSSiPs launched New theatre paperwork finalised New theatre whiteboards ordered and launched	N
2.	Enhance the accessibility, efficiency and capacity of planned surgical services to meet demand and facilitate repatriation of services provided for local patients in the independent sector.	⇔	⇔	⇔	Trauma & Orthopaedics Redesign paper includes VFC started September 2019 SSDEC implemented in August 2019	N
3.	Deliver the best possible care, experience and outcomes for trauma and emergency patients from their arrival to discharge by comprehensively reviewing and improving emergency surgery and trauma services. Further pathway work to support	⇧	⇔	⇔	Trauma & Orthopaedics Service Redesign paper signed off- recruitment started SDEC underway Ophthalmology redesign underway	N
4.	Optimise theatre and bed utilisation to ensure delivery of activity is as efficient as possible; make delivery of day case surgery the norm rather than the exception.	⇔	⇔	⇔	Proven ability to close 15 beds in surgery Site requirements mean that beds cannot stay closed but may need to be reallocated. Beds Theatre reconfiguration ongoing	N
5.	Offer a flexible, stimulating environment to develop and work within in order to provide a sustainable, highly engaged workforce able to meet patients' needs.	⇔	⇔	⇔	New internal meeting schedule planned and communicated Medical workforce moving to substantive sustainable Nursing vacancy rate down below 6% Restructuring to release time for leadership activities	N

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Consistently deliver high quality, compassionate care across all services.			Develop and deliver a comprehensive quality programme which will improve quality, safety and patient experience by focussing on and embedding the basics of care.	Achieve and sustain a Good CQC rating by 2020. Quality programme in place, including patient satisfaction, complication management, mortality, length of stay and unplanned re-admissions.		MH/ML & ET	Awaiting CQC report Aiming for section 29a to be lifted and rating of "requires improvement" NATSSiPS and LoCSSIPs launched New quality team in place Ward managers on RCN leadership programme which focuses on quality improvement 2 wards undergoing "pathways to Excellence programme Deputy Divisional Chair on international leadership course.	CQC report outcome as yet unknown Embedding NATSSips and LOCSips Release time for courses and quality improvement projects
			Review progress with delivering GIRFT recommendations. Develop, agree and deliver plan to implement and embed remaining actions to optimise expected benefits.	Plan in place		EB & LC	Divisional GIRFT delivery programme (all specialties) – discussed at Divisional Board Action plan tracker being developed	Priorities for funding to be identified and agreed
			Lead a review of quality and safety of PEG insertion service. Implement any recommendations.	Review concluded. Plan in place for implementation of recommendations		SG	Good progress	
			Enhance patient safety and service efficiency in Anaesthetics and ICU by developing and implementing business cases for paperless records in Anaesthetics and ICU.	Business case developed and approved. Plan in place for delivery		EB	Business Case completed, not planned for 2019	Priorities for funding to be identified and agreed IT
			Improve patient experience and prevent long term adverse health impacts by developing and implementing an ICU Survivor Programme	Plan developed and implemented			From year 3	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Enhance the accessibility, efficiency and capacity of planned surgical services to meet demand and facilitate repatriation of services provided for local patients in the independent sector			Improve patient experience and reduce service costs by streamlining outpatient pathways and introducing efficient service models which will sustainably deliver all national standards and offer referral times that benchmark equitably with those offered by surrounding providers, including One Stop clinics and patient-initiated follow ups (e.g. in Ophthalmology, General Surgery (laparoscopic) & Urology)	RTT First OPA waiting times NP:Fup Service costs		MM/LC & EB	Virtual fracture clinic implemented September 2019 Urology One Stop Clinics set up SDEC started August 2019 Workforce redesign signed off in T&O adverts in the very near future SDEC consultants appointed	Priorities for funding to be identified and agreed Failure to deliver efficiencies due to lack of space Inability to recruit
			Work with STP partners to improve accessibility and sustainability of services within the STP including: •Vascular Surgery: develop and agree an OBC and FBC to develop a STP Vascular Surgery Network with hub at Lister Hospital. •Paediatric ophthalmology •Paediatric urology •Lithotripsy	Plan in place		LC	STP Vascular Surgery Development Board in place with good pan-organisational engagement. OBC being developed with options appraisal. Capital funded allocated under STP Wave 4	Highly complex business case – challenging project timetable linked to capital availability
			Work with STP to remove variation from clinical pathways, particularly gastro and gall bladder	Plan in place; pathways redesigned and standardised		EB &LC	Straight to Test implemented Emergency gall bladder covered within SSDEC paper	Capacity shortfall (space & resource) Failure to recruit

			Develop and deliver a phased plan to repatriate planned care undertaken in the independent sector back to the Trust including: •Ophthalmology •Orthopaedics •Gastroenterology incl Endoscopy	Plan in place; work repatriated; Market share; Income						EB & LC	Ophthalmology and T & O plan complete include repatriation element	Difficult to recruit areas Consultants unwilling to take on extra sessions due to risk of incurring tax charges on pension contributions One off costs to support redesign with different workforce models may prove prohibitive (T & O)
			Ensure the future sustainability and quality of the breast surgery service by developing a sustainable service model and pathways which provide a consistently high quality, timely experience for patients.	Service model designed and in place; quality and access time measures in place						EB & LC	Breast GIRFT visit November 2019 - recommendations to support service redesign Vascular GIRFT recommendations on Length of stay and ITU use	Vascular service redesign paper

Clinical Priority	Previous period	This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Enhance the accessibility, efficiency and capacity of planned surgical services to meet demand and facilitate repatriation of services provided for local patients in the independent sector (continued)			Plastic Surgery will actively contribute to ensuring a sustainable, high quality dermatology /skin health service model for local patients by: •co-designing and supporting delivery of a high quality local dermatology service with other specialties and partners •Assessing the benefit and sustainability of offering Mohs micrographic surgery (MMS) and Sentinel Node Biopsy service within the Trust and for skin cancer	Assessment concluded and action plan in place		ML	Division undertaking review of feasibility of Dermatology moving under the umbrella of Plastic Surgery.	Space and resource
			Enhance the financial sustainability and quality of head and neck services. Review Trust OMFS requirements, identify preferred partner and agree new service contracts/SLAs to deliver.	Review conducted; preferred partner identified; SLA		LC		
			Ensure timely access to colonoscopy. Redesign pathways to meet demand and provide high quality patient experience including: - respond to changes in demand following the roll out of FIT - co-design and implement a Straight to Test model for colonoscopy	Access times; RTT; pathway redesign and implementation; straight to test model implementation; Market Share; Patient Experience		LC	STT has been put in place with a RAS to support this. D&C modelling and more efficient ways of using the theatre times being looked at.	D & C modelling will show a shortfall of both physical and manpower resource – solutions to address to be identified
			Improve patient care, outcomes, experience and mortality by assessing the benefits and sustainability of offering gastroenterology fibroscan as an alternative to liver biopsy.	Quality programme in place, including patient satisfaction, complication management, mortality, length of stay and unplanned re-admissions.		LC	Action plan created Advert out for band 7 hepatology CNS	

Clinical Priority	Previous period	This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Deliver the best possible care, experience and outcomes for trauma and emergency patients from their arrival to discharge by comprehensively reviewing and improving emergency surgery and trauma services. Further pathway work to support frail patients.			Provide a consistent high quality, sustainable trauma service by: •Developing and implementing a Trauma Strategy. •Reviewing and revising the Hand Trauma service and workforce model •Improve Fracture Clinic efficiency and patient experience by implementing virtual fracture clinics	Patient satisfaction, mortality, length of stay and unplanned re-admissions. National Hip Fracture Database demonstration of improvement. Fracture Clinic costs		EB &MM	T & O redesign paper signed off Adverts for AHPO's in progress Virtual Fracture Clinic started Business case in progress for Hand Trauma Service	Priorities for funding to be identified and agreed IT support
			Agree and implement a new service model to provide sustainable 7 day eye casualty and urgent eye services to meet local needs.	Patient satisfaction, service availability and accessibility		MM	Service redesign in progress	Recruitment or inter trust collaboration
			Continuously improve the management and quality of emergency surgical care by : •Fully integrating emergency surgery into the ED, ensuring that surgical decision-making occurs promptly after arrival. •Reviewing the impact of the consultant of the week model and the potential benefits of extending the model to other surgical specialties. •Developing and implementing proposals to sustainably optimise theatre availability for emergency surgery, without adversely impacting planned care •Developing Hot Clinic and ambulatory pathways to provide sustainable alternatives to ED attendance.	Time for ED patients to be placed on emergency surgery pathway Achievement of ED standard for surgical patients Patient satisfaction, length of stay, outcomes, unplanned re-admissions LoS; Access to Surgery; Theatre utilisation ED attendances		EB	SSDEC paper complete. Consultant appointed enabling suitable cover on SAU supporting ED flow and emergency Surgery Middle grade gaps still in place ACP started	Recruitment

Clinical Priority	Previous period	This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5					Lead	Progress to date, including successes	Risks, including support required
Optimise theatre and bed utilisation to ensure delivery of activity is as efficient as possible; make delivery of day case surgery the norm rather than the exception.			Benchmark and model theatre capacity required to meet expected demand to 2024, whilst demonstrating increasing efficient utilisation.	Benchmarking and modelling completed						GB	In progress. Theatre capacity still not adequate – mapping underway. Services moving out of acute services and procedure rooms being implemented rather than theatres.	
			Implement revised theatre session patterns and timetable in order to meet demand and optimise use of available capacity.	Demonstrable progress towards upper quartile theatre performance as measured by Model Hospital.						GB	From year 2 Trial of ATOM scheduling tool in orthopaedics. And as above	
			Model longer term theatre configuration and capacity requirements to inform Estates Strategy. Assess impact of alternative options including innovative anaesthetic models on future capacity requirements.	Longer term theatre planning completed and requirements fed into Estates strategy.						GB	In progress	Procedure room development
			Following modelling work for theatre configuration, agree medium to long term plan to provide theatre capacity required. Develop and submit a business case for the redevelopment of and / or increase in theatres.	Modelling work completed; business case developed and submitted, with agreed timescales for completion.						GB	From year 2 Business case complete	Procedure room options. Renting of external space from community providers
			Release acute site theatre and ward space, improve patient access and strengthen community-based MDT service models by relocating and integrating pain services within locality teams.	Plan in place; patient experience						GB	From year 2 AS ABOVE	

			Achieve and sustain a significant increase in day case rates by developing a regional (nerve block) anaesthesia service to release theatre capacity.	(BADS) day case rates; LoS Patient Experience; Implementation and delivery of benefits for theatre availability						VP	DC rates have increased in larger proportion to EL operations from 17/18 to 18/19, ongoing reviews	None identified

Clinical Priority	Previous period	This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Optimise theatre and bed utilisation to ensure delivery of activity is as efficient as possible; make delivery of daycase surgery the norm rather than the exception (continued)			Benchmark and model bed capacity required to meet expected demand to 2024, whilst demonstrating increasing improved LoS and day case rates.	(BADS) day case rates; LoS; Patient Experience		PW	15 beds form surgery closed but site requirements using beds for medical patients - outlying patients	Increasing demand
			Reassign inpatient bed capacity according to specialty needs to meet demand and efficiency levels.	(BADS) day case rates; LoS; Patient Experience		PW		
			Develop, agree and implement a sustainable and appropriately staffed Enhanced Recovery Programme across all surgical specialties to reduce LoS, improve quality and enhance patient experience.	Enhanced Recovery Programme implemented; QoS; LoS; Patient Experience		ET	Trust wide Enhanced Recovery programme. Business case for Division complete shared with Sue Wilkinson	Delayed – strategic approach not established.
			Review the model and use of ITU beds. Develop, agree and implement a sustainable model going forwards which supports support optimal length of stay, flow, use of ITU beds, patient outcomes and experience.	ICNARC incl LoS, outcomes, access to ITU		JB/ WC	Winter and summer plan devised – with finance to approve.	

Clinical Priority	Previous period	This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Offer a flexible, stimulating environment to develop and work within in order to provide a sustainable, highly engaged workforce able to meet patients' needs			Mitigate the potential adverse service impact on service quality and sustainability as a result of a future reduction in trainee doctors by: •Develop and deliver a plan to achieve Royal College of Anaesthetics Accreditation •Developing and implementing a business case for a Hand Fellow role and hand Therapists to clinically sustain and qualitatively enhance the hand surgery service •Deliver consistent, sustainable service quality and mitigate risks related to the availability and allocation of trainee doctors by achieving Guidelines for the Provision of Intensive Care Services (GPICS) in ICU	Impact understood and plan in place; QoS, mortality		MH	Service Redesign takes account of potential adverse impact on reduced trainees from Deanery by use of alternative workforce models ACP programme Hand Fellow mentioned earlier Accreditation review not yet started	Recruitment
			Developing and implementing alternative non-medical and enhanced roles.	Impact understood and plan in place; QoS, mortality		MH	Part of service redesign and workforce models. ACP in SAU, recruiting for Orthopaedic redesign.	
			Ensure service quality and sustainability by proactively developing a divisional consultant supply forecast to inform recruitment, retention and succession planning for all consultant posts. Develop divisional workforce plan and deliver.	Impact understood and plan in place; ongoing recruitment		EB & MH	Trajectories being worked on, planned retirements etc	
			Enhance service quality and workforce recruitment & retention by developing and delivering a divisional plan to expand and increase research activity across all surgical specialties to raise skill sets, enrich job roles and benefit patients.	Plan in place		MH & ET	Part of service redesign and workforce models. ACP in SAU, recruiting for Orthopaedic redesign.	

Women & Children's Division's Strategic Clinical Priorities Highlight Report
Reporting Period: Quarter 2

No.	STRATEGIC CLINICAL PRIORITY	OVERALL CONFIDENCE RATING	Progress vs 2019/20 plan	Risks	Items to note / for discussion	Items to escalate? Y/N
1.	Achieve an outstanding CQC rating for our services by transforming services in line with National Ambitions and Drivers to improve outcomes	⇔	⇔	⇔	Investment in staff and equipment Non-recurrent funding from LMS	Y Non recurrent funding
2.	Ensure services are at a scale to deliver long-term clinical and financial sustainability	⇔	⇔	⇔	New fertility consultant appointed. Looking to widen paediatric haematology to include sickle and thalassaemia.	N
3.	Protect market share and grow birth numbers by delivering Better Births Ambition and maintaining the quality and reputation of our services	⇔	⇔	⇔	Continuity of Carer – issue finding staff wishing to work to this model. ENHT have strong participation in LMS	N
4.	Deliver consistent, high quality care and ensure patients receive the most appropriate care for their condition, from those most clinically appropriate to deliver it, and in the most appropriate setting	⇔	⇔	⇔	PNMH midwife in post but this in non-recurrent funding from LMS	Y Non-recurrent funding
5.	Develop and establish Private Patient Services, offering greater choice to our local community and improving financial sustainability	⇔	⇔	⇔	Women's services progressing well and scoping Children's. Marketing and IT support required for website to allow online bookings and payment	N
6.	Create a sustainable workforce by becoming 'Employer of Choice' for our Services, helping reduce challenges of retention and recruitment	⇔	⇔	⇔	Work commenced on exploring expanded roles / increased skillsets for nurses. Work ongoing within Division on culture	N

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Achieve an outstanding CQC rating for our services by transforming services in line with National Ambitions and Drivers to improve outcomes			Improve outcomes for women and children by implementing the national safety agenda: MatNeo/Attain/Saving Babies Lives/Each Baby Counts /PReCePT/PMRT/	Mortality		KC, MD	Making clear progress on these maternity safety drivers. LMS deliverables agreed for 19/20. Children's Network Excellence Group now in place.	
			Embed the Better Births Ambitions • Increase the no. of women receiving continuity of carer • Introduce personalised care plans • Increase the choice offer available to women • Embed maternity safety initiatives (10 steps to safety, SBLCB v2 • Produce post-natal improvement plan	Maternity survey, e-referral data, Monitoring, Local Maternity System Governance		FK	Birth-rate plus paper presented to board. LMS funding four midwives for 12/12 for CoC. Plans in place to target area of deprivation with a mixed risk team. Gap analysis on personalised care underway. Digital choice offer and supporting material is being delivered by LMS.	Currently not staffed to birth rate plus for business as usual. Investment in staff and equipment required to meet this strategic aim.
			Develop a safety culture across the Local Maternity Systems by imbedding the Human Factor Philosophy and multi-professional training through a safety collaborative	Training completes and embedded		MD	MDT training across LMS to be implemented by 2020. Human factors train the trainer set up. LMS wide monthly safety forum in place.	Ability to release staff for training.
			Develop a perinatal mental health service and Continuity of Carer pathway for vulnerable women	Perinatal mental health service and continuity of carer in place for 51% of women by 2021.		RM	PNMH midwife funded by LMS in post now. Perinatal Mental Health Pathway developed. Pilot for CoC is in progress in North Herts community team. Pilot for triaging CPT referrals started. PNMH midwife clinic started at Lister in September 2019.	Funding from LMS non-recurring. Additional funding required to pay for staff

			Community hubs to be established, where maternity services, particularly ante- and postnatally, alongside other family-orientated health and social services provided by statutory and voluntary agencies. Community hubs should work closely with their obstetric and neonatal unit(s)	Community hubs established						LP	Named consultant in post. Relaunch of diamond team in October. Home birth pilot in Royston & Rurals. Continuity of care strategy being written for 2020 to achieve 35 % CoC.	Lack of resources and equipment
			Right staff in the right place with the right skills; ensuring correct staff to birth ratios	Staff to birth ratios						KC	Birth rate plus report done and presented to board. Another staffing paper to go to Board in Nov 19.	Funding requirement for uplift.
			Improve the appropriateness of referrals to Urogynaecology so that patients present to secondary care only after all community based interventions have failed	Number of rejected referrals						Uro gynae CD	NHSI 100 day challenge. STP/CCG meetings	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Ensure services are at a scale to deliver long-term clinical and financial sustainability			Establish specialty clinics in both Children's and Gynae in order to protect and grow market share	Specialty clinics established and promoted; market share		Gynae CD	Endometriosis clinic set up. New fertility consultant appointed. Looking to widen paediatric haematology to include sickle and thalassaemia. Increasing allergy services.	Need additional allergy nurse and haematology nurse
			Establish endometriosis clinic and gain centre accreditation and British Society of Urogynaecology (BSUG) accreditation	Endometriosis Accreditation 2019 BSUG Accreditation 2019		FC	RCOG provisional accreditation achieved. Will be applying for full accreditation by April 2020	
			Understand potential impact of CUH Children's Hospital and mitigate against potential loss of market share	CUH business case analysed and plan in place		CD	We already refer to them and may make referrals easier. Hub working possible	Risk of staff loss.
			Develop, engage and lead the Children's STP workstream to redesign patient pathways, benchmarking services; greater co-operation across provider boundaries, creation of an adolescent unit to ensure sustainability and most efficient patient pathways	Children's STP workstream established; plan in place to review pathways		CD	Frist quarterly meeting held. Priorities are being established.	
			Provide inpatient care for our Children closer to home by ensuring estate, facilities and skills are in place to facilitate repatriation of work to ENHT (e.g. HDU; PSCU; NICU L3) once agreed with Specialised Commissioners	Plan in place to repatriate work; discussions held with Commissioners		CD	From year 3	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Ensure services are at a scale to deliver long-term clinical and financial sustainability (continued)			Providing outpatient care for our Children closer to home by ensuring estate, facilities and skills are in place to facilitate repatriation of work to ENHT (e.g. Cardiology; Gastro; Allergy; Haem) once agreed with Specialised Commissioners	Plan in place; discussions held with Commissioners		CD	From year 2	
			Establish better working relationship with GPs, especially on our boundaries to develop understanding of the services we provide to protect our market share (e.g. through GP engagement events and open evenings)	GP engagement plan in place; more women choosing to give birth at the Trust, measured through market share		KC	Have initiated working in some St Albans Surgeries. Working with new marketing team and webpage developers to improve profile of services. Have marketing plan which is to be presented at ARM.	Withdrawing midwives out of PAH catchment. Financial risks.
			Establish shared governance across the Local Maternity System (LMS) to ensure better clinical and financial sustainability	Regular attendance at LMS meetings; engagement		MD	From year 2 Set up safety forum to included sharing of learning and guidelines. LMS Safety & Quality Governance Lead role is being advertised.	
			Explore opportunities for improved clinical procurement efficiency and savings by working across systems	Working group in place; plan to identify potential savings in place			From year 2 We are part of the procurement working group	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Protect market share and grow birth numbers by delivering Better Births Ambition and maintaining the quality and reputation of our services			Embed the Better Births Ambitions to introduce innovative ways of midwives providing care for women and ensure Trust has met 35% Continuity of Carer target by 2020 and then work to achieve maximum levels of Continuity of Carer	Maternity survey, e-referral data, Monitoring no. of women on CoC pathway,		FK	Pilots set up and under evaluation. Plans developed for further role out. Continuity of care strategy being written for 2020 with refresh trajectories CoC currently approximately 7%.	Unlikely to meet the target of 35% by March 2020. Lack of resources. Staff wishing to work this model.
			Improve patient outcomes by implementing the national safety agenda: MatNeo/Attain/Saving Babies Lives/ Each Baby Counts /PReCePT/PMRT/	Outcomes; Model Hospital, Reduction in stillbirths, National Measures		KC; MD MD; JL	Making clear progress on these maternity safety drivers. LMS deliverables agreed for 19/20. Children's Network Excellence Group now in place.	Elements of SBLCB2 in risk register.
			Develop pathways that meet woman's choice and personalised care plans to deliver better women's and families' quality and increase market share	Quality; Model Hospital; Market share		FK; RB	LMS workstream on choice and personalisation; developing pre booking choice offer available in digital format. GAP analysis on personalised care underway to identify staff training and woman's needs	
			Strengthen our participation in the Maternity Voices Partnership (MVP) to better our women's experience by responding to patient feedback	Patient experience; Friends and Family		RB	Completed. Strong participation in MVP evident and demonstrable	
			Strengthen the working relationship with GPs, especially on our boundaries to develop understanding of the services we provide to protect our market share (e.g. through GP engagement events and open evenings)	Increased referrals; market share; events held		MD	Have initiated working in some St Albans Surgeries. Working with marketing and webpage teams in the Trust to increase profile of services	Withdrawing midwives out of PAH catchment. Financial risks.

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Deliver consistent, high quality care and ensure patients receive the most appropriate care for their condition, from those most clinically appropriate to deliver it, and in the most appropriate setting			Review Paediatric Pathways with Primary Care (including Emergency Paediatric Pathways; ADHD Shared Care) to ensure best experience for patients	Pathways reviewed and changes implemented		CD	Acute Paeds CD has started this work stream. Paediatricians continue to meet with primary care regarding specific pathways.	
			Create an Acute Community Children's Nursing Service (7 day service) to reduce reliance and impact on the Emergency Department	Service commenced; reduced attendances at ED		CD	At very early stage. No progress to report.	
			Develop a perinatal mental health service and Continuity of Carer pathway for vulnerable women	Service commenced		RM	PNMH midwife in post. Pathway to be developed.	Funding from LMS non-recurring
			Develop improved patient pathways and experience for our Children and Young People with Mental Health needs	Pathways reviewed and changes implemented		CD	Joint meetings with HPFT, Social care and Education regarding frequent attenders and individual care plans started.	
			All staff to have access to a Child's shared electronic health record (SystemOne) to ensure patient safety, better quality and ease of use	Access for all staff		CD	At very early stage. No progress to report.	
			Develop, engage and lead the Children's STP workstream to redesign patient pathways, benchmarking services; greater co-operation across provider boundaries, creation of an adolescent unit to ensure sustainability and most efficient patient pathways	Participation; pathways reviewed		CD	First quarterly meeting held. Priorities are being established.	

Clinical Priority	Rag Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Deliver consistent, high quality care and ensure patients receive the most appropriate care for their condition, from those most clinically appropriate to deliver it, and in the most appropriate setting (continued)			Expand and strengthen Transitional Pathways across Children's Services, ensuring successful handovers across providers and best patient experience Consistently and sustainably achieve the clinical effectiveness standards	Quality; successful handovers		CD	National work to start soon. Local pathways will be aligned accordingly.	
			Review, promote and expand the usage of apps and social media to improve patient experience and ensure patients have tools to self manage where appropriate, e.g. paediatric asthma; paediatric diabetes	Use of apps; social media updated		CD	Some apps already in use. Further development to be discussed at specialist meeting.	
			Review gynaecology service patient pathways to maximise efficiencies; increasing use of telephone clinics where appropriate; implementing GIRFT; benchmarking Model Hospital to reduce length of stay and improve patient outcomes	Review Gynaecology Service Pathways; Enhanced Care Pathway; Reduced Length of Stay; Model Hospital		Gynae CD & DC, Matron and GM.	Lead for enhanced recovery identified. GIRFT action plan completed. Increased TLH. Increased out pt hysteroscopy. Telephone clinics still to be set up. Agreed pathways with SAU and ED.	Delay due to training of nurse colposcopist.
			Establish a patient and carer's group to ensure we are working collaboratively with children, young people and their carers, in line with the RCPCH framework	Group established; young person feedback incorporated into service decisions		CD	From year 2	

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Develop and establish Private Patient Services, offering greater choice to our local community and improving financial sustainability			Identify and develop children's private services for which there is local demand	Services developed and promoted		JB	Only just starting	Marketing Consultant buy in.
			Identify and develop enhanced private maternity services for which there is local demand	Services developed and promoted		MD	Marketing plan developed to increase market share. Hypno birth training to be delivered in November. Several activities underway to raise funding: • flyers developed • giving tree to be placed in maternity	Marketing and IT support for on line booking
			Use communication platforms to promote private services with a distinct brand and develop advertising materials showcasing services, in order to grow income	Plan in place		MD	Part of marketing strategy, leaflet being updated, setting up Instagram account with Communications team.	Support for Website.

Clinical Priority	RAG Previous period	RAG This period	Key Action	Key Success Measures 2019/20	Timescale Years 1 - 5	Lead	Progress to date, including successes	Risks, including support required
Create a sustainable workforce by becoming 'Employer of Choice' for our Services, helping reduce challenges of retention and recruitment			Drive a positive, open and honest culture building on Trust Values, staff and cultural surveys, staff engagement	Staff survey		AP	Action plan for staff survey result. Regular review through SMT meetings. SCORE culture survey maternity with feedback sessions	
			Mitigate reliance on medical model and staffing by exploring expanded roles for staff through a creative career development and training environment to support retention and recruitment, supported by: •Nurse Consultant •Introducing Criteria Led Discharge •Gynae Nurse-Led Pathways •Midwifery-led Clinics for high risk women •Midwives providing specialist care within Continuity of Carer pathways •Supported and funded training and development program for all staff •Continued links with the University (research and teaching) to build reputation	Criteria Led Discharge using Enhanced Care Pathway Length of Stay Training courses		RB	Leads for enhanced recovery identified, agreed to feed into Trust enhanced recovery meetings. Nurse colposcopist appointed. Multiple preg continuity of carer. Scanning midwives. EPU nurses being trained in early pregnancy scanning. Criteria led discharge in Children's areas and succession plans to be looked at.	Training would require investment.
			Create a flexible working environment to support our staff and services, looking at working hours, shift patterns etc to meet needs of the millennium generation	Review completed; changes implemented		KC & CD	Offer flexible working. Support career break. Roster requests. Details of flexible working environment needs to be agreed at Divisional level. Support secondment. Set up a breaks workshop.	

East and North Hertfordshire NHS Trust

Agenda Item: 9

TRUST BOARD - PUBLIC SESSION – 6 NOVEMBER 2019

Integrated Performance Report – Month 6

Purpose of report and executive summary (250 words max): The purpose of the report is to present the Integrated Performance Report Month 6 to the Trust Board. Key challenges and mitigations under each domain are identified within the report.		
Action required: For discussion		
Previously considered by: QSC – 29.10.19, FPC – 30.10.19		
Director: All Directors	**Presented by:** All Directors	**Author:** All Directors / Head of Information and Business Intelligence

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

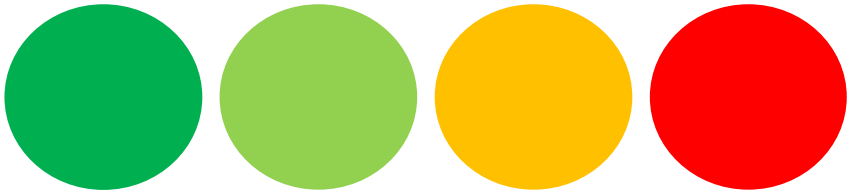
Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): Key challenges and mitigations under each domain are identified within the report.

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

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 06 | 2019-20



Contents

East and North Hertfordshire NHS Trust

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Safe & Caring Services	**Patient safety** World Patient Safety Day (17th Sept) was marked by celebrating good reporting. One team per division were awarded with certificates - the acknowledgement was well received. **Improvement initiatives - deteriorating patients** Three themes have been developed to drive improvement projects: early recognition, structured response and use of fluid balance charts. Presently the availability and state of equipment used for recording observations and carrying out treatment when a patient is deteriorating is being reviewed. The Patient Breakthrough Series Collaborative is aiming to launch in January 2020. Personalised treatment plans are now in regular use. **Safer Invasive Procedures** On the 1st of October 2019 the trust launched the ENHT Safer Invasive Procedure Policy. The launch event was well received and the endoscopy, cardiology and outpatient departments have agreed to be the next test areas for implementing their LocSSIPs. This shall be supported by a new 'NatSSIP Committee' going forward. **Clinical Excellence framework** The second session to the first wave of 20 ward leaders participating in a 12 month RCN leadership programme, has taken place. All ward leaders participating in this RCN Leadership course will have to participant in Action Learning sets. The first cohort of wards undergoing the Clinical Accreditation Excellence Framework are near to have their first final review and then the decision by the credentialling panel. The second cohort of wards have been nominated to undertake their self-assessment. **Complaints Management** While complaints management remains a priority for the trust, to both improve timeliness of response and overall reduction in open complaints, improvement has been noted from Jan 2019- Aug 2019 with an overall 50% reduction in open cases. Responding to complaints within the agreed timeframe has increased to 75% year to date for this Trust. All divisions are improving on their response times, enabling the complaints team to draft responses in a timelier manner.	**Incident Reporting** The trust remains an outlier from an under-reporting perspective based on latest NRLS data. Contributing to this is delayed incident sign-off and divisions have been asked to develop incident closure trajectories. **Supporting staff to sustainably and continuously improve** A Head of Quality Improvement has been appointed and is supported by two new improvement coaches and a data analyst. The team is coaching improvement initiatives and providing teaching in improvement methodology at the same time. This aims to build capacity whilst driving improvement. Discussions are underway regarding the trust's QI 'way' i.e. the improvement methodologies; and the QI team is involved in the educational review around organisational capacity. **Serious Incident Management** Planned Duty of Candour sessions continue to be delivered through Drs Inductions and RCA training sessions. Information is also being captured of where DoC is included within other training sessions delivered by clinical staff. Divisions are reporting significant improvements in their RCA incident backlogs; although closing action plans remains challenging. Meanwhile there are challenges to complete serious incident investigations in a timely way and additional support is being sought while the recruitment of third SI investigator progresses. Work is underway to move to new Datix cloud with the implementation stage about to commence having secured the IT elements of the plan.	 **Rachael Corser** **Director of Nursing**

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Effective Services	**Mortality** Mortality can be considered a proxy measurement of the overall care delivered to patients. Timely, high quality care, delivered by motivated, well-trained and caring staff results in better outcomes including reduced adverse events, complications and deaths. Mortality rates at the Trust have improved over the last 5 years as measured by both of the major methods: HSMR and SHMI. **Hospital Standardised Mortality ratio (HSMR)** This measure is based on a basket of 56 patient groups with relatively predictable mortality and records deaths in hospital. Performance has been consistently in the 'as expected range'. Refreshes since April 2019 (rolling 12 months to January-March 2019) have seen HSMR fall to within the 'better than expected' range. The latest HSMR for the rolling 12 months to July 2019 is 86.92. HSMR is generally available 3/12 in arrears. The significant reduction since the last reported figure of 93.1 (R12M to May-19) is due to a change in data source from Dr Foster to CHKS and results from the fact that these two providers have different timeframes for re-basing their datasets. **Summary Hospital-level Mortality Indicator (SHMI)** This is a measure of mortality for all inpatients including up to 30-days post-discharge. Historically, ENHT's SHMI has been up to 10 points higher than the HSMR, which was thought to be related to the onsite hospice at Mount Vernon. However, over the last 2 years the gap between SHMI and HSMR has steadily reduced. Since the rolling 12 months to December 2018 SHMI has now fallen to less than HSMR for the corresponding period. From January 2019 the indicator is now available monthly rather than quarterly. The latest SHMI for the rolling 12 months to May 2019 is 91.33 ('as expected' range). SHMI is now generally available 4/12 in arrears. **Crude mortality** This measure is available the day after the month end and has demonstrated a consistent decrease over the last 5 years. It is the factor with the most significant impact on HSMR. The Trust's crude mortality has continued on a downward trend. **Learning from deaths** In addition to the monitoring of mortality indicators, the Trust remains committed to reviewing and learning from the deaths of those who die while in our care, even when the death is expected. Deaths in scope: September 2019 = 85. 2019-20 deaths reviewed: September = 54. Year to 30 September 2019 deaths in scope = 631; Related mortality reviews = 350.	**Mortality** Although overall Trust mortality is within the 'as expected' (SHMI) or 'better than expected' (HSMR) range, there are often still subgroups of patients where mortality is raised. Monthly Mortality Alerts meetings are held following Dr Foster refreshes to consider new and existing elevated diagnosis groups. This small group led by the Medical Director with Coding, Information, Mortality, and Quality Leads, monitors our data (HSMR, SHMI & CUSUM alerts), confirms whether the issue relates to incorrect coding and where uncertainty/concerns persist, instigates a retrospective review of a sample of the deaths underlying the mortality rate to identify learning and any changes that may be beneficial, e.g. to the patient pathway or to Trust policies and procedures. Information from the Mortality Alerts work feeds into the Mortality Surveillance Committee which has responsibility for mortality governance. A decision has recently been made to change our provider for mortality metrics from Dr Foster to CHKS. This will involve a number of changes to the data we use for monitoring purposes. We are currently in a transition phase until the end of our Dr Foster contract at the end of March 2020. The use of CHKS data for reporting purposes will be introduced during this time. For the purpose of this IPR Crude Mortality, HSMR and Re-admissions has been taken from CHKS iCompare. Current outliers under review: HSMR - nil SHMI - Diverticulosis & Diverticulitis; Congestive heart failure CUSUM alerts - Nutritional deficiencies (1); Perio, endo; & myocarditis cardiomyopathy (2); Poisoning by psychotropic agents (1) (taken from latest Dr Foster data). **7-day Services** The delivery of consistently high quality care to patients across the entire week has been a challenge for the Trust. There is currently a difference (not statistically significant) in mortality between weekend/weekday emergency admissions. Recent months have seen improvements in HSMR for both weekday admissions now 'better than expected' and particularly for weekends 'as expected'. Consultant review within 14 hrs of emergency admission is lower at the weekend and an area where we need to improve our performance. Snapshot Specialty audits are in progress to assess our current compliance with the 14-hour review requirement. While an Associate Medical Director for Reduction in Unwarranted Variation is shortly to be appointed, a new 7 Day Services Steering Group is now established with the principal aim of achieving compliance with the 4 priority Keogh standards by April 2020.	 **Michael Chilvers** **Medical Director**

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Responsive Services	**ED Performance** The Trust ED performance in September was 85.07%. There was a positive start to the month but flow deteriorated in the 2nd and 3rd weeks in the month. However, the trust did retain the above 85% performance which is a significant and remains relatively strong performance in comparison to surrounding acute providers. Positively the trust continues to report 0 12-hour trolley breaches. **Cancer Performance** The trust delivered 4 compliant national cancer targets in August to include; 2ww, 31-day 1st definitive, 31-day subsequent for radiotherapy and chemotherapy. The 62-day target was 73.3% which is below the revised trajectory of 82.1%. The original actions as set out in the high impact tumour recovery plans remain the correct actions but there has been slippage against the delivery of these. In addition, there are emerging risks regarding PET-CT delays at the Paul Strickland Scanning Centre and histopathology reporting delays due to a combination of reduction in WLIs as a result of the Consultant tax issue and a Consultant retirement. Both these issues are being addressed but have introduced additional delays to achieving performance compliance. This is coupled with patient choice which is high in August and September and a high number of patients who had already breached who needed treating in month to support the forecast improvement in October. **RTT Performance** September RTT Incomplete performance was 85.17%, below recovery trajectory but remaining around the national position. There were 18 x 52 week breaches reported at month end. The focus for the next 9 weeks (the remaining period for the RTT transformation manager) will be to deliver the transition plan from the existing external RTT transformation manager and validators, to the in house team. This will require developing the internal team's capacity and capability to take on this task. This task is vital to deliver organisational ownership and sustainability around RTT performance. **Diagnostics** DM01 performance for September was 0.22% against the national standard of 1%. This is above the recovery trajectory, demonstrating great compliant performance, and has been sustained for 5 months. **Stroke Performance** Performance for September was 79.7%, demonstrating significant improvement from August performance. 4 hr target taking into account the exclusion of the Inter hospital transfer and inpatient stroke was 81.5%. This significant improvement has been delivered by ensuring stroke bed capacity is maintained through ring fenced stroke beds. In conjunction with maintaining the capacity there has been good escalation and step down of patients from stroke beds and lastly, stroke bed capacity is a standard agenda item in the bed meetings.	**Month 7 Operational performance overview** ED – 85% retained - **amber** Cancer – 73.3% negative impact of delayed recovery actions; patient choice; treating breached patients – **red** RTT – 85.17% - amber; 52 week breaches 18 – **red** DM01 – 0.22% compliant and sustained performance- **green** Stroke – 79.7% significant improvement in month - **amber** **Cancer Performance** The appointment of Dr Nikhil Vasdev, Consultant Urologist as the Associate Medical Director for cancer performance, transformation and innovation has been a positive move, resulting in significantly increase clinical focus on cancer performance. Nikhil is focusing on a programme of clinical meetings and actions in support of the high impact RAPs. The forecast delivery of 62-day target compliance in October remains very much the focus of attention. The incremental recovery trajectory was always going to be challenging. The original trajectory reflected the deterioration seen in August, to reflect the impact of patient choice, but was rejected by our regulators. **Capacity summit** The forecast bed requirements based on D&C modelling have been shared with the teams with the aim of sharing the challenge and asking for ideas for bed solutions and bed equivalent solutions. The most demanding time required is in January with an additional 46 beds needed to deliver 92% occupancy. Capacity will be delivered through a combination of additional beds via the winter ward; admission avoidance through the use of ambulatory pathways and LoS reduction through initiatives such as Criteria Led Discharge and Discharge home to Assess. The capacity plans are aligned with other winter initiatives such as management of infectious patients and system winter planning.	 **Julie Anne Smith** **Chief Operating Officer**

Performance Headlines

East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Well-led Services	**Temporary Staffing** Agency expenditure decreased by 171k compared to month 5. This meant that the Trust was under the agency ceiling by £91k in month. To achieve the NHSI agency ceiling target for 19/20, the Trust cannot spend more than £1,021m per month for the remaining 6 months. **People Strategy** The Trust has started the development of the new five-year people strategy. A range of engagement methods have been utilised including surveys, Twitter conversations and engagement sessions. From this, a set of themes have emerged creating and outline plan for the next 5 years. In addition, the Trust has developed a five-year workforce plan considering the changing environment of healthcare provision as part of the wider system. **LEND Sessions – Autumn 2019** The LEND Sessions for the Autumn are underway and will be focusing on the topics of 'Psychological Safety' and 'Effective Feedback'. **Randomised Coffee Trials** Randomised coffee trials (RCT) will return this Autumn after the success of last year. The success last year has led to this year's events receiving sponsorship from ENHT Pharma. This year's RCT will be known as 'Costa Conversations' **Education** A review of all learning and education functions has been completed and a recommendation has been provided. The outcome is aimed at providing increased, appropriate, impactful and equitable access and resources across the Trust and become an aid to recruitment and retention. A Deputy Director of Learning, Education and Development has been appointed on an interim basis to take forward the recommendation of the review and amalgamate the services.	**Sickness Absence** There has been an increase in sickness absence in September and full time equivalent (FTE) days lost due to musculoskeletal issues (MSK) is 38% higher than September 2018. The increase is seen across most staff groups and in all divisions except cancer services. The divisions with the greatest increase are Clinical Support Services and Surgery; where there is a significant increase in MSK related short term sickness. The Health at Work Service and the HR Business Partner will work with the division to identify staff health and wellbeing strategies to address these issues. The Trust will also be following up on recommendations from HSE regarding staff MSK issues. **Appraisals** Appraisal rates decreased from 87.2% to 86.3%. The volume of appraisals increases in September which often impacts the compliance rate. The divisions are being supported with weekly reporting and business partner support. The appraisal working group has now been set up to redesign the appraisal process to be launched in April 2020. **Culture** The new staff survey was launched on Oct 1st and a communications plan underway and divisional activity is planned to encourage completion. While this occurs, work continues in response to the most recent staff survey results. The Trust is moving to an approach of a continuous improvement plan on staff experience. Key areas of focus are on diversity and inclusion, well-being and leadership development. Women and Children division are being used as a model example for improving staff experience. **Flu Campaign** The staff flu vaccine campaign began on 30th September. Our ambition is to vaccinate all staff who have direct patient contact. There is a CQUIN goal to achieve an 80% uptake of flu vaccinations in frontline staff by 28th February 2020. However, our ambition is to vaccinate all frontline staff. 1088 frontline staff have received the flu vaccine in the first two weeks, this represents 25%.	 **Duncan Forbes** **Chief People Officer**

Performance Headlines

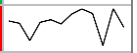
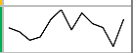
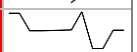
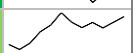
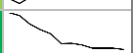
East and North Hertfordshire NHS Trust

Domain	Positive Performance	Challenges	Lead Director
Sustainable Services	The Trust has accepted its break even Control Total for 19/20. The Finance Committee and Trust Board reviewed and approved the financial and operational plan for the year ahead at meetings in March 2019. Budget plans for the new year were signed off by divisional management teams and similarly SLA activity plans for 19/20 have been reviewed and validated. In addition, the Trust has agreed SLA's with local and national commissioners for 19/20 in line with required national timelines. All contracts are signed. At M6 the Trust reports financial delivery that is in line with its agreed plan. SLA income performance reports a significant over achievement against plan, this mainly results from increased emergency admissions. The In contrast the Trust reports a significant overspend against pay budgets YTD. This has been driven by pressure across medical and nursing budgets. This results in part from increased WLI spend used to deliver activity levels rather than the anticipated improvement in theatre and outpatient productivity. However, significant weaknesses in the control environment pertaining to the utilisation of temporary staffing across medical and nursing budgets have also characterised financial performance in the YTD. The Trust reports delivery of CIP savings of £7.0m YTD. Whilst this is behind target, this level is significantly higher than historic values of achievement at this early stage in the financial year. In conjunction with other STP organisations the Trust will during Q3 initiate procurement activity to seek alternative Pathology provision arrangements from 20/21. It is expected that this will realise significant financial and service sustainability benefits. During the course of 19/20 the Trust finance department has facilitated the roll out of an extensive package of financial e-learning material across 300 budget holders from the Trust. Uptake and completion rates have been excellent across this initial phase, and it is expected that the programme will be key in helping to support improved decision making and financial performance across the Trust. The Trust continues to expand the scope and sophistication of its BI universe at pace to support the need to supply relevant, timely and accurate data to clinicians and managers to enable more effective decision making and plan delivery.	Key elements of the finance performance represent a significant concern for the Trust. The income over performance YTD largely relates to emergency activity, this is neither operationally sustainable for the Trust or affordable by commissioners. The significant overspend against pay budgets is largely driven by the impact of CCG QIPP scheme shortfalls and the consequent need to maintain capacity that has been expected to close. The Trust has undertaken through deep dive analysis into the drivers underpinning emergency growth and shared this fully with commissioners, and remains committed to working collaboratively to manage this position. In addition, the Trust continues to face challenges in the delivery clinical productivity targets and also weaknesses in the management of medical and nursing temporary staffing costs. This underlying position is not sustainable and requires redress if the Trust is to deliver its 19/20 financial plan. The Trust Executive have introduced a number of remedial forecast mitigation work streams in order to support outturn delivery. These include weekly IFD oversight groups for both Medical Staffing and Nursing Management which have been identified as key in maintaining oversight and management of the control environment. The groups are led by Executive Directors and will implement agreed improvement plans for these staffing areas. Further IFD work streams have been set up in respect of establishing a high impact focus on Pathology, Pharmacy and Procurement costs in the second half of the year. In addition, the Trust has introduced tighter controls for the review and approval of admin and senior managers temporary staffing costs. Regular reports on the effectiveness of these mitigation programmes will be provided to the Finance and Performance Committee and weekly Executive Committee meetings.	 **Martin Armstrong** **Director of Finance**

Single Oversight Framework

East and North Hertfordshire NHS Trust

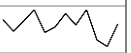
Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Overall	CQC rating	-	Jul-18	-	-	Requires improvement	
Caring	Written complaints - rate	Quarterly	Sep-19	Local	1.9	1.7	
Caring	Staff Friends and Family Test % recommended - care	Quarterly	Q1 2019-20	National	80.9%	67.8%	
Safe	Occurrence of any Never Event	Monthly (six-month rolling)	Apr-19 - Sep-19	National	0	2	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Oct-19	National	0	5	
Caring	Mixed-sex accommodation breaches	Monthly	Sep-19	National	0	0	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	Sep-19	National (excl. IS)	95.0%	96.9%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	Sep-19	National (excl. IS)	90.0%	88.9%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	Sep-19	National (excl. IS)	93.0%	92.3%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	Sep-19	National (excl. IS)	93.0%	98.1%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	Sep-19	National (excl. IS)	93.0%	94.3%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	Sep-19	National (excl. IS)	93.0%	100.0%	
Safe	Emergency c-section rate	Monthly	Sep-19	Local	15%	16%	
Organisational health	CQC inpatient survey	Annual	2018	National	8.0	7.8	
Safe	Venous thromboembolism (VTE) risk assessment	Quarterly	Q1 2019-20	National	95%	94.9%	
Safe	Clostridium difficile (C. difficile) plan: C.difficile actual variance from plan (actual number v plan number)	Monthly (YTD)	Apr-19 - Sep-19	National	0	-2	
Safe	Clostridium difficile – infection rate	Monthly	Sep-19	NHSI	25.3	29.66	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Sep-19	National	0.59	1.44	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly (12-month rolling)	Sep-19	National	8.11	5.28	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Monthly (12-month rolling)	Sep-19	National	18.40	16.81	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Aug-18 - Jul-19	National	100	86.9	
Effective	Summary Hospital-level Mortality Indicator	Monthly (12-month rolling)	Jun-18 - May-19	National	100	91.2	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	Apr-19 - Sep-19	National	54.2	43.5	

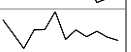
Finance

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Financial sustainability	Capital service capacity	Monthly	Sep-19	National	1	4	
Financial sustainability	Liquidity (days)	Monthly	Sep-19	National	1	4	
Financial efficiency	Income and expenditure (I&E) margin	Monthly	Sep-19	National	1	4	
Financial controls	Distance from financial plan	Monthly	Sep-19	National	1	1	
Financial controls	Agency spend	Monthly	Sep-19	National	1	1	

Operational performance

A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	Sep-19	National	95%		
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	Sep-19	National	92%		
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Aug-19	National	85%		
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Aug-19	National	90%		
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	Sep-19	National	1%		
The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who:							
Dementia assessment and referral	a. have a diagnosis of dementia or delirium or to whom case finding is applied	Monthly	-	National	95%	-	
	b. who, if identified as potentially having dementia or delirium, are appropriately assessed	Monthly	-	National	95%	-	
	c. where the outcome was positive or inconclusive, are referred on to specialist services	Monthly	-	National	95%	-	

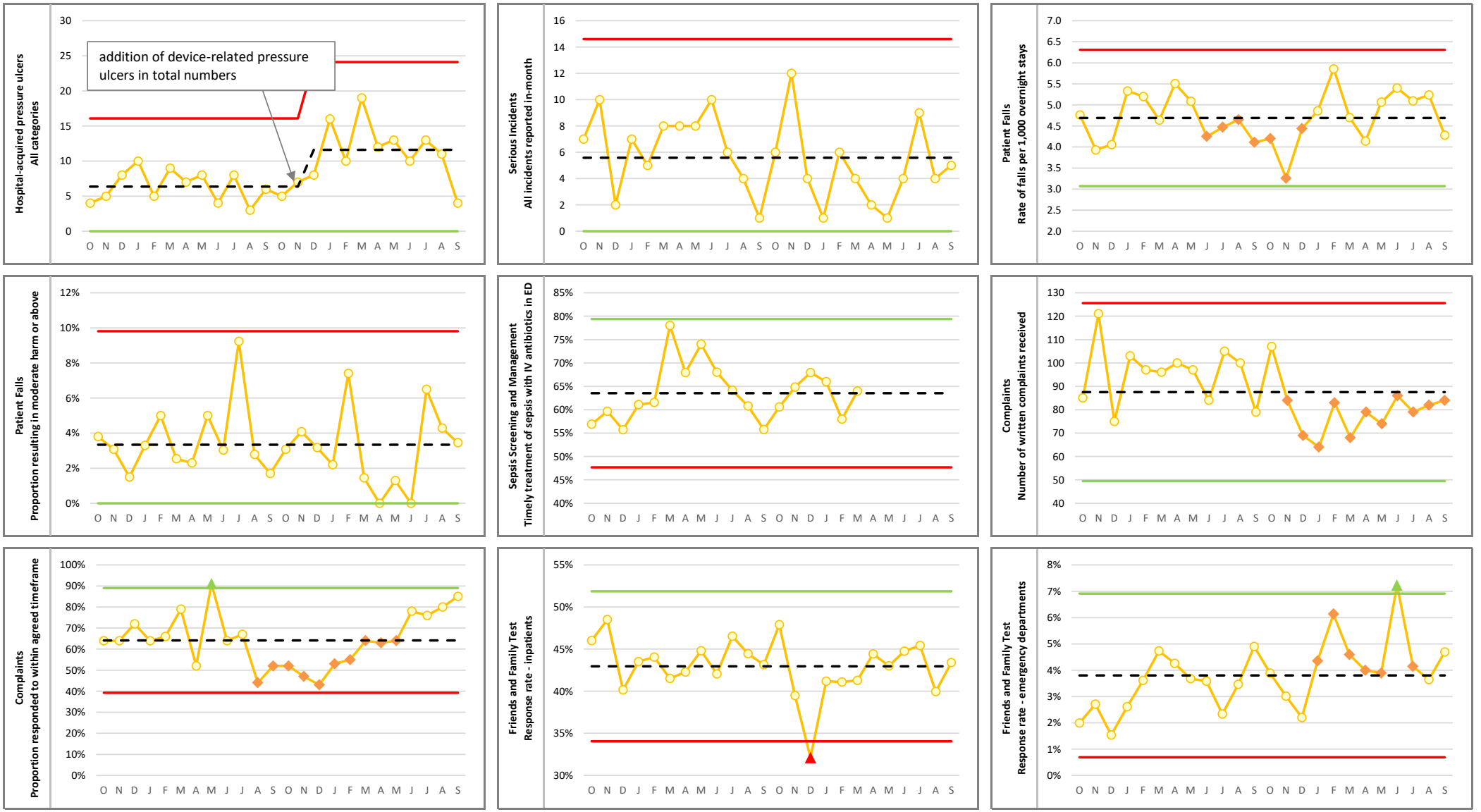
Leadership and workforce

Organisational health	Staff sickness	Monthly	Sep-19	Local	3.4%	4.3%	
Organisational health	Staff turnover	Monthly	Sep-19	Local	12.0%	12.8%	
Organisational health	Proportion of temporary staff	Monthly	Sep-19	Local	-	10.0%	
Organisational health	NHS Staff Survey Recommend as a place to work	Annual	2018	National	62.6%	53.9%	
Organisational health	NHS Staff Survey Support and compassion	Annual	2018	National	82.8%	80.0%	
Organisational health	NHS Staff Survey Teamwork	Annual	2018	National	65.4%	64.0%	
Organisational health	NHS Staff Survey Inclusion	Annual	2018	National	73.9%	71.8%	
Organisational health	BME leadership ambition (WRES) re executive appointments	Annual	2018	National	7.4%	0.0%	

Quality Improvement Dashboard

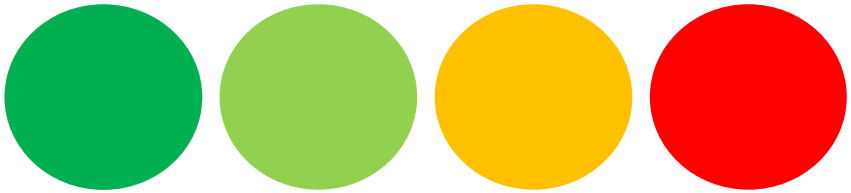
Safe, Caring and Effective Services Headline Metrics

East and North Hertfordshire NHS Trust



Safe Services

Month 06 | 2019-20



Key Issues

Safety Thermometer
- Harm-free care (for all and new harms) remain better than the national average in September. Both All harms and New Harms have f allen slightly since August.

Patient Falls
- In September 58 falls were recorded:
  - There were 40 falls which resulted in no physical harm to the patients involved;
  - 15 falls resulted in a low level of harm;
  - 3 incidents resulted in moderate harm;
  - In September the surgical division achieved a sustained period of 7 consecutive months below the divisions mean number of falls per calendar month measured using a 33 point SPC chart. This is indicative of a sustained improvement or a performance desirable special cause variation.

Serious Incidents & Never Events
- There was 1 Never Event reported in September.
- There were 5 serious incident reported in September:
  - 1 injury to arms of patient following aggressive incident;
  - 1 hospital acquired thromboembolism;
  - 1 possible delay in recognising severe effects of chemotherapy;
  - 1 wrong tooth extraction (never event);
  - 1 maternity incident relating to a concealed haemorrhage (? downgrade).

Infection Control
- MRSA bacteraemia = 1 incidence in September.
- C difficile infections = 5 reportable incidences in September.
- E.coli bacteraemia = 2 incidences in September.
- MSSA bacteraemia = 0 incidences in September.
- Hand hygiene compliance = 91.4%.

Hospital-acquired Pressure Ulcers
- Since April 2019 we have reported 68 Cat 2 and above pressure ulcers.
- There were the following reported for September:
  - Category 4 = 0;
  - Category 3 = 0;
  - Category 2 (D) = 1;
  - Unstageable = 0;
  - SDTI = 3 - 1 device related;
  - MM (D) = 1.

Sepsis
- ED overall sepsis 6 compliance = 53% for Q2 (peaked in August).
- Each intervention is now measured separately:
  - O2 = 94%;
  - Blood cultures = 86%;
  - Antibiotics = 84%;
  - Fluid challenge = 92%;
  - Lactate = 90%;
  - Fluid measurement = 87%.
- IP overall sepsis 6 compliance = for Q2.
  - O2 = 91%;
  - Blood cultures = 59%;
  - Antibiotics = 32%
  - Fluid challenge = 62%;
  - Lactate = 90%;
  - Fluid measurement = 77%.

VTE
- Potential harm from hospital acquired thrombosis are presented to Serious Incident Review panel – there was one case presented to panel in September.
- Medication chart has been revised to include time of initial VTE assessment, thereby clarifying reassessment timeframes. This will be launched in Jan 2020.

Executive Response

Safety Thermometer
- The Trust is in the highest (best performing) quartile for harm-free care in September.

Patient Falls
- Review of data through the harm free care collaborative has identified themes such as:
  - Increase in the number of falls occurring at night; an improvement noted in September with 41% of falls reported at night. Ou r aim is to achieve a target of less than 45% split in falls occurring at night for the following 6 months, whilst sustaining the current day time frequency. (If achieved this could result in a 5% reduction in falls trust wide)
  - Poor adherence to bay watch processes;
  - A number of clinical areas in the surgical division are not monitoring postural blood pressures in ambulant patients ages 65 or over which is not in keeping with Trust policy, a review of Datix for a five-month period gave an indication that 26% of falls reported in the surgical division are consistent with having been caused by a postural drop.
- These themes shall be key drivers through Harm Free Care Quality Improvement efforts.
- Falls activity in acute hospitals is effected by seasonal variation occurring at a higher frequency in winter months and at a lower frequency in summer months (national trend), it is likely that the improving performance noted in recent months was a natural seasonal variation and not necessarily due to an improved performance.

Serious Incidents, Never Events & Safer Surgery
- ENHT approach to NatSSIPs was launched at a learning event on 01/10/19.

Infection Control - High Impact Interventions (HII)
- HII audit scores in September recorded on Meridian by ward nursing teams were 95% in 8 out of 10 categories. 2 categories we re below 95%; Inpatients Environment 81.5%, Clinical non-inpatients Environment 93.6%.

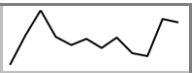
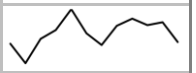
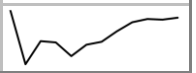
Hospital-acquired Pressure Ulcers
- The trust is engaging in wave 2 of NHSI stop the pressure campaign. 2 clinical areas have been identified and shall participa te in this national programme, with support of QI team. Monthly monitoring of data continues.
- the focus of the collaborative will be to improve all aspects of care around skin inspection.
- Plans for improvement include:
  - React to red Campaign launched
  - Tick a turn initiative re-launched
  - New documentation - launched
  - Care competencies await ratification by NMEC

Sepsis
- Where treatment was delivered in ED:
  - The average time to antibiotics was 42 mins;
  - The average time to Fluid challenge on time = 66 mins.
- Common non-compliance themes (Emergency Dept.) include:
  - New confusion / change in mental state not recognised in NEWS2 score despite being documented at triage and doctors clerking;
  - Urine output / fluid balance not measured from time of admission/deterioration.
- Where treatment was delivered in to Inpatients:
  - The average time to antibiotics was 147 mins;
  - The average time to Fluid challenge on time = 133 mins.
- Common non-compliance themes (Inpatient) include:
  - Time to escalation by ward team after first red flag;
  - Time to doctor review after trigger (was 52 mins in July, longer in August & Sept – most of 'golden hour');
  - New antibiotics being written on regular side of drug chart rather than stat (addressed at junior doctor training).
- There is QI project with Acute Chest Team with an aim to reduce readmission and mortality from sepsis secondary to pneumonia. The focus is on uncomplicated patients with CAP and require care according to both BTS and Sepsis guidelines; improving safety netting inform ation.
- Inpatient data is currently being reviewed to also reflect more accurate time to treatments from Q3 & to include time of esca lation and time of doctors' review.

VTE
- Thrombosis Action Group continue to meet - HAT inclusion criteria will be reviewed at the next meeting
- Root cause analysis from VTE cases are now presented by discharging consultant to SIRP.
- Following changes to the national criteria an increase in 40% of cases has been seen compared to the same period 2018/19, the refore a new VTE/HAT structure is under review with pharmacy, nursing and medical leads.

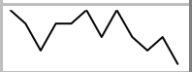
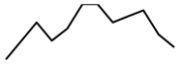
Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Trend
Safety Thermometer	Harm-free care All harms	93.9	95.7	97.0	98.1	96.9	96.6	96.8	96.4	96.9	96.2	96.1	97.7	97.6	
	Harm-free care New harms	97.8	98.1	99.6	99.6	98.9	98.2	98.4	99.1	99.5	98.4	99.1	99.0	98.5	
Patient Falls	Number of patient falls	72	65	49	63	91	81	69	61	77	75	77	70	58	
	Rate of patient falls per 1,000 overnight stays	4.0	4.2	3.3	4.4	4.9	5.9	4.7	4.1	5.1	5.4	5.1	5.2	4.3	
	Number of patient falls resulting in serious harm	0	2	0	1	3	3	2	0	0	0	3	0	0	
Events and Incidents	Number of Never Events	0	1	1	0	0	0	0	0	0	0	1	0	1	
	Number of Serious Incidents	5	6	12	4	1	6	4	2	1	4	9	4	5	
Infection Control	Rate of MRSA incidences per 100,000 bed days	0.6	0.0	0.0	0.0	0.0	0.0	0.0	5.7	0.0	0.0	5.7	0.0	5.9	
	Rate of c.difficile incidences per 100,000 bed days Healthcare-associated (Category 1 & 2)	18.8	-	-	-	-	-	-	11.4	16.6	17.1	28.7	34.4	29.7	
	Rate of c.difficile incidences per 100,000 bed days Hospital-onset (pre April-19)	10.1	23.1	6.0	11.5	16.8	12.4	0.0	-	-	-	-	-	-	
	Rate of e.coli incidences per 100,000 bed days	18.3	11.5	11.9	11.5	16.8	37.1	5.6	17.1	27.7	11.4	28.7	11.5	11.9	
	Rate of MSSA incidences per 100,000 bed days	8.1	0.0	11.9	11.5	5.6	0.0	5.6	5.7	0.0	11.4	5.7	5.7	0.0	
	Hand hygiene audit score	95%	94.3%	73.1%	82.2%	81.7%	76.3%	80.9%	82.0%	86.0%	89.6%	90.8%	90.7%	91.4%	

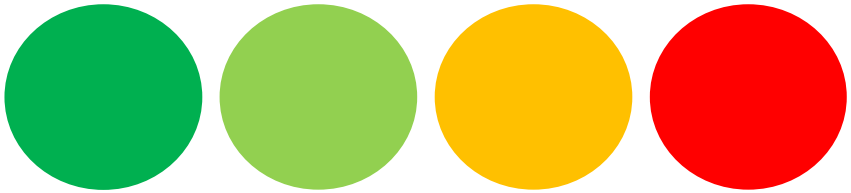
Safe Services

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Trend
Hospital-acquired Pressure Ulcers	Category 4	0	1	0	0	1	0	0	1	0	0	0	0	0	
	Category 3	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Category 2	2	4	3	1	3	3	4	2	4	2	1	2	0	
	Category 2(D) Device-related	-	-	1	0	2	0	1	0	1	1	1	3	1	
	Mucosal membrane (D) Device-related	-	-	-	1	5	1	1	0	0	0	1	0	1	
	Unstageable	1	0	0	0	2	1	4	0	2	0	2	2	0	
	SDTI Excluding STDI (D)	3	0	3	6	3	5	9	9	6	7	8	4	2	
VTE	VTE risk assessment	95%	96.6%	95.7%	91.4%	96.5%	95.9%	96.5%	96.8%	91.4%	96.9%	tbc	tbc	tbc	
Sepsis Screening and Management	Emergency attendances with Sepsis - sample size	50	-	-	-	-	-	-	23	19	17	33	22	15	
	Emergency attendances receiving IVABs within 1 hour of Red Flag	90%	-	-	-	-	-	-	90.0%	84.0%	88.0%	88.0%	86.0%	73.0%	
	Inpatients with Sepsis - sample size	50	-	-	-	-	-	-	27	21	19	10	10	6	
	Inpatients receiving IVABs within 1 hour of Red Flag	90%	-	-	-	-	-	-	40.0%	40.0%	0.0%	40.0%	40.0%	17.0%	
	Sepsis six bundle compliance	90%	-	-	-	-	-	-	tbc	tbc	tbc	48.0%	68.0%	40.0%	

Caring Services

Month 06 | 2019-20



Key Issues

Friends and Family Test (FFT)

- The proportion of positive responses to the Inpatients, Postnatal Ward & Postnatal Community were better than the respective Trust Targets in September.
- The proportion of positive responses to the A&E (88.9%), Outpatients (94.5%) and Maternity Antenatal (92.3%) are below the relevant Trust Targets in September
- Response Rate for Inpatients has improved to 43.4% for September which is above the Trust Target. A&E Response Rate has improved from August (3.6%) to September (4.7%), with total number of response increasing from 498 in August to 676 in September.
- Response Rate for Maternity Birth has improved from 22.3% in August to 23.7% in September but remains below the Trust Target.
- Response Rates for Maternity Postnatal Ward was higher than the Trust Target at 94.3%, the first time this financial year. Postnatal Community Response Rate remains at 100% for September.

Complaints

- Total number of complaints received since April 2019 = 484, with 84 complaints received in September. The breakdown by division is as follows:
  - Surgery 35
  - Medicine 23
  - W&C 11
  - CSS 11
  - Cancer 3
  - Operations 1
- 100% of complaints received were acknowledged within 3 working days.
- 85% were responded to within the agreed timeframe.
- Since April 2019 an average of 75% of complaints across the divisions have been responded to within the agreed timeframe.
- As at end of September 2019 we have 86 open complaints.

Executive Response

Friends and Family Test (FFT)

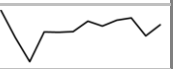
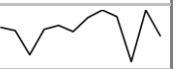
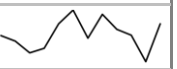
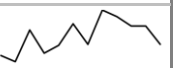
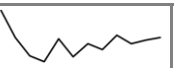
- The inpatient / day case percentage of patients who would recommend the Trust remains higher than the national average. The response rate continues to exceed the latest national average response rate of 24.8% and is above the Trust's target of 40%.
- The highest proportion of positive comments from inpatient / day case patients relate to staff, and the care and treatment provided. Negative comments relate to the temperature on the ward, noise from other patients, food, and communication between staff.
- The majority of feedback from patients in A&E is positive particularly in relation to staff being kind and caring and providing an excellent service. Negative feedback relates to improved communication about waiting times and provision of food. 16 patients out of 676 who responded to the A&E FFT survey were unlikely or extremely unlikely to recommend the service.
- Outpatients compliment staff for being kind and helpful and for the care, treatment and information provided. There are concerns about waiting times in clinics and lack of information about reasons for the delays. Other concerns relate to appointment letters, administration of appointments and the cost and availability of car parking spaces.
- The majority of women compliment the staff for the support, care and information provided to them during their birth experience. On the postnatal ward 2 out of 106 women would not recommend the service. Women would like a quieter environment, better provision of recliner chairs, more information about what's happening and the plans for discharge.

Improvement efforts - Complaints

- We are continuing to work an improvement plan to achieve less than 120 open complaints across all divisions within this Trust. This has been achieved in this quarter.
- Since Jan 2019 our monthly open complaints has gone from 160 to 86 in September 2019.
- Case handlers have been meeting regularly with divisions to support the complaints process.

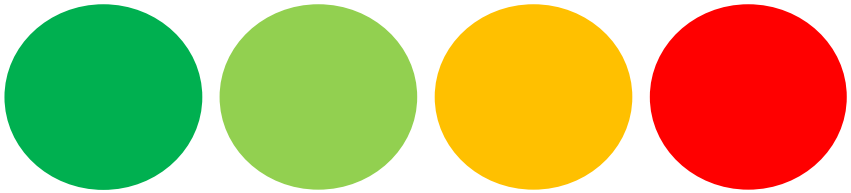
Caring Services

East and North Hertfordshire NHS Trust

Domain	FFT	Metric	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Trend
Friends and Family Test	Inpatients	Proportion of positive responses	95%	96.8%	97.2%	97.5%	97.3%	96.8%	96.8%	96.7%	96.4%	96.9%	97.8%	96.9%	96.9%	
		Total number of responses	1,778	2,322	1,874	1,391	2,094	1,791	1,889	1,994	2,022	2,095	2,263	1,760	1,959	
		Response rate	40%	47.9%	39.5%	32.1%	41.2%	41.1%	41.3%	44.4%	43.0%	44.8%	45.4%	39.9%	43.4%	
	A&E	Proportion of positive responses	90%	90.5%	89.9%	85.2%	90.2%	90.9%	89.7%	92.5%	93.9%	92.7%	83.8%	94.0%	88.9%	
		Total number of responses	1,241	560	417	297	610	806	671	546	559	1,008	624	498	676	
		Response rate	10%	3.9%	3.0%	2.2%	4.4%	6.1%	4.6%	4.0%	3.9%	7.2%	4.1%	3.6%	4.7%	
	Maternity	Antenatal care Proportion of positive responses	93%	100.0%	100.0%	96.8%	92.5%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	92.3%	
		Birth Proportion of positive responses	93%	96.5%	95.7%	94.1%	94.7%	98.1%	100.0%	96.1%	99.4%	97.3%	96.5%	92.9%	98.1%	
		Birth Total number of responses	137	141	139	135	132	157	71	128	159	74	115	98	106	
		Birth Response rate	30%	27.8%	30.3%	29.8%	30.2%	39.1%	16.3%	30.5%	34.6%	17.4%	24.5%	22.3%	23.7%	
		Postnatal ward Proportion of positive responses	93%	91.4%	86.9%	83.3%	91.6%	91.7%	83.1%	87.4%	89.7%	86.5%	92.2%	88.8%	94.3%	
		Postnatal community Proportion of positive responses	93%	100.0%	100.0%	94.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Outpatients	Proportion of positive responses	95%	93.9%	93.6%	95.2%	94.1%	94.4%	95.5%	94.5%	96.2%	95.8%	95.4%	95.4%	94.5%	
		Total number of responses	-	1,733	1,982	1,683	2,037	2,281	5,320	1,980	4,100	3,943	3,613	3,313	2,448	
Complaints		Number of written complaints received	92	107	84	69	64	83	68	79	74	86	79	82	84	
		Rate of written complaints received	1.9	1.9	1.6	1.6	1.1	1.6	1.3	1.6	1.4	1.7	1.5	1.8	1.7	
		Proportion of complaints acknowledged within 3 working days	75%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	
		Proportion of complaints responded to within agreed timeframe	80%	52%	47%	43%	53%	55%	64%	63%	64%	78%	76%	80%	85%	

Effective Services

Month 06 | 2019-20



Key Issues

Please note that the data source for Crude Mortality, HSMR and Re-admissions is now being taken from CHKS iCompare. Historic figures have been revised where available.

Crude Mortality
- The in-month crude mortality rate improved to 8.2 deaths per 1,000 admissions in September.
- The rolling 12-months crude mortality rate improved to 10.9 deaths per 1,000 admissions in the 12 months to September, and remained better than the most recently available national rate of 11.5 deaths per 1,000 admissions.

Hospital-Standardised Mortality Ratio (HSMR)
- The in-month HSMR improved to 70.73 in July, and remained better than the standard (100).
- The rolling 12-months HSMR improved to 86.92 in the 12 months to July, and remains in the better than expected range.
- HSMR is usually available 2-3 months in arrears.

Summary Hospital-level Mortality Indicator (SHMI)
- The latest SHMI release for the 12 months to May saw a slight increase to 91.33.
- Dr Foster provides detail of which diagnosis groups have significantly elevated SHMI. The latest available information is for the rolling 12 months to April 2019. There are currently 2 significantly elevated diagnosis groups: Diverticulosis & Diverticulitis (200.0); and Congestive Heart Failure (146.7).
- SHMI is now available on a monthly basis, 4 months in arrears. This should improve the timeliness of our investigation into areas of potential concern.

Re-admissions
- The total re-admission rate improved from 9.0% in June to 8.5% in July 2019.

Learning from Deaths
- Where mortality reviews give rise to significant concern regarding the quality of care or the avoidability of the death, the case is subject to further scrutiny and discussion at the relevant Specialty clinical governance forum. The outcomes of these reviews are then considered by the Mortality Surveillance Committee.

Executive Response

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

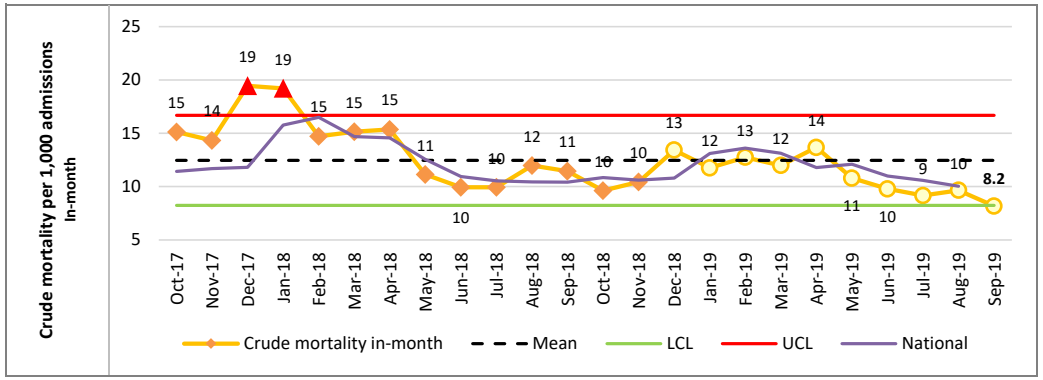
Crude mortality
- This measure is available the day after the month end and has demonstrated a consistent decrease over the last 5 years. It is the factor with the most significant impact on HSMR.
- The improvements in mortality have been as a result of a combination of corporate level initiatives such as the mortality review process and more directed areas of improvement such as the identification and early treatment of patients with sepsis, stroke, etc.
- While our crude mortality has steadily improved over recent years, up until the rolling 12 months to June 2018, the Trust's performance remained below the national average. Since this point in time our crude rate has continued to fall and our performance has been consistently better than the national average.

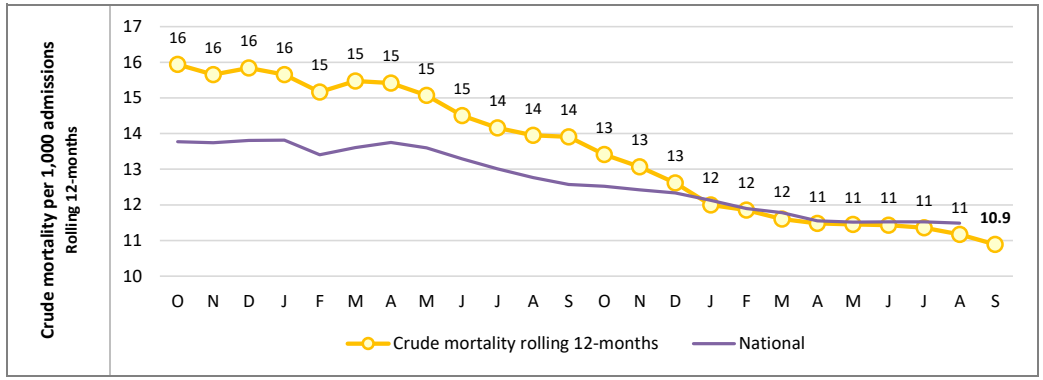
Hospital Standardised Mortality ratio (HSMR)
- While our current HSMR of 86.92 makes us well positioned in the 'better than expected' range, we remain focussed on driving further improvement.

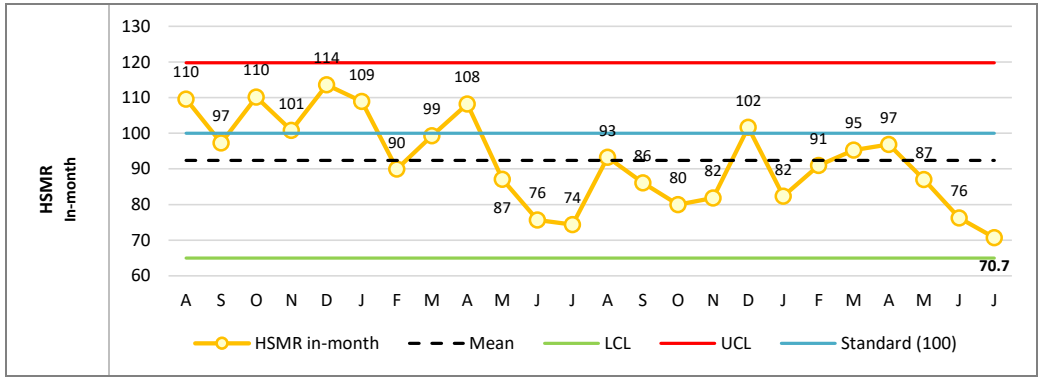
Summary Hospital-level Mortality Indicator (SHMI)
- As with HSMR, the recent significant improvements to SHMI have been welcomed. With regard to the 2 outlying diagnosis groups: reviews showed some process and coding concerns regarding Congestive Heart Failure, which are being addressed via a joint clinical/coding review initiative at weekly MDT meetings. The coding review of deaths underpinning the Diverticulosis & Diverticulitis deaths showed only a few errors and no concerns requiring clinical review. Monitoring will continue at Mortality Alerts meetings.

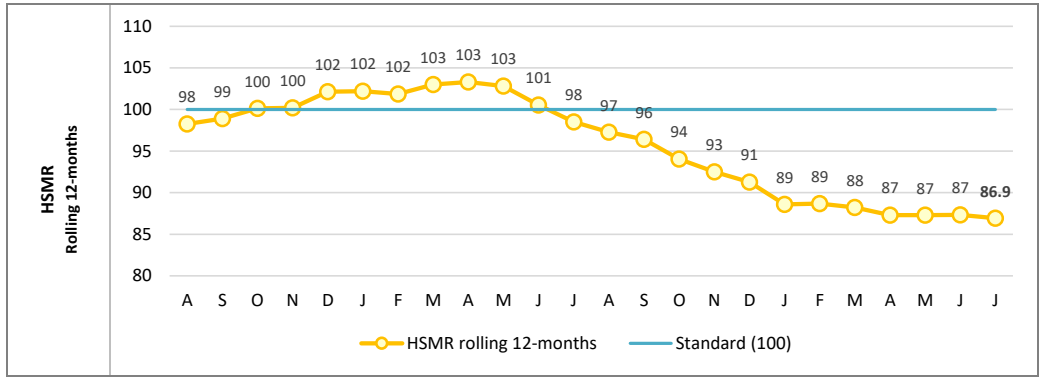
Re-admissions
- Historically the Trust reported higher than expected levels of re-admissions compared to the national average. However, the last three years have seen a consistent improving trend.

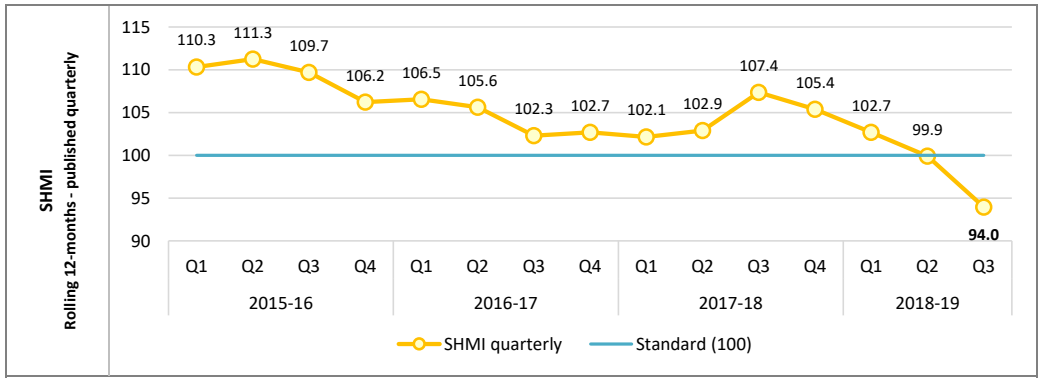
Learning from Deaths
- In addition to the outcomes of cases escalated to Specialties being considered by the Mortality Surveillance Committee (where proposed remedial/development action is approved/recommended), the quarterly Learning from Deaths report includes a summary of key themes emerging from these cases. This detail is shared with all Trust Specialties and with interested working groups such as Deteriorating Patient, End of Life and Seven Day Services Steering Group.

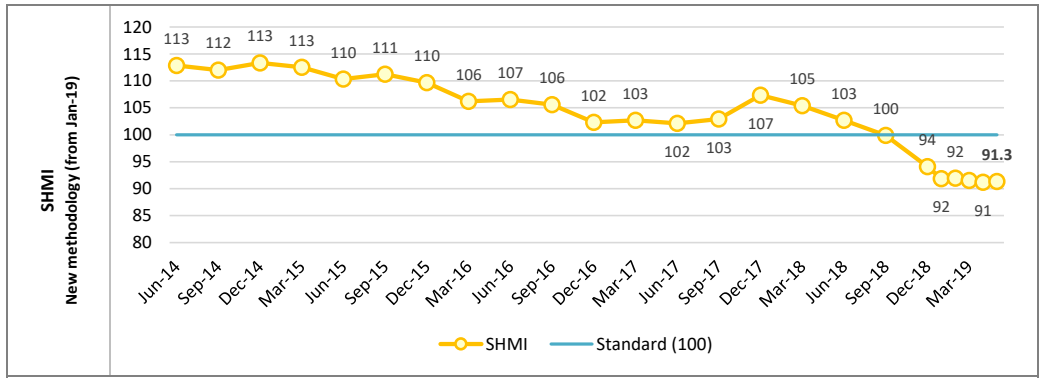

Crude mortality per 1,000 admissions In-month
Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19
Crude mortality in-month
Mean
LCL
UCL
National


Crude mortality per 1,000 admissions Rolling 12-months
O N D J F M A M J J A S O N D J F M A M J J A S
Crude mortality rolling 12-months
National


HSMR In-month
A S O N D J F M A M J J A S O N D J F M A M J J
HSMR in-month
Mean
LCL
UCL
Standard (100)

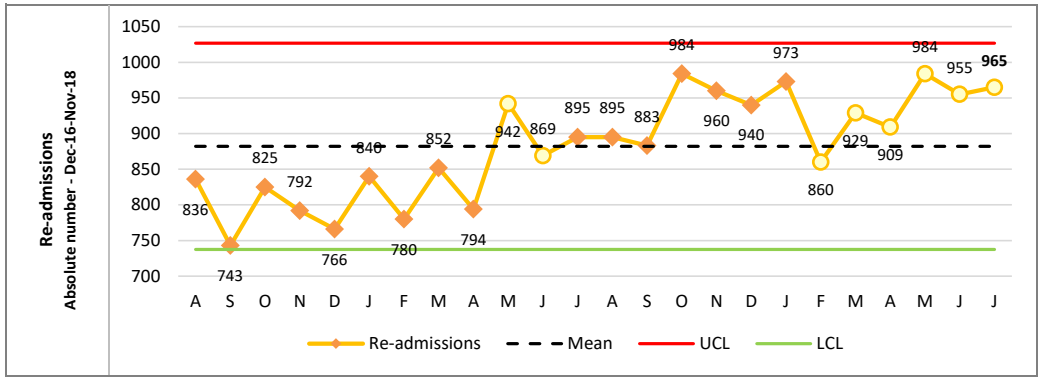

HSMR Rolling 12-months
A S O N D J F M A M J J A S O N D J F M A M J J
HSMR rolling 12-months
Standard (100)

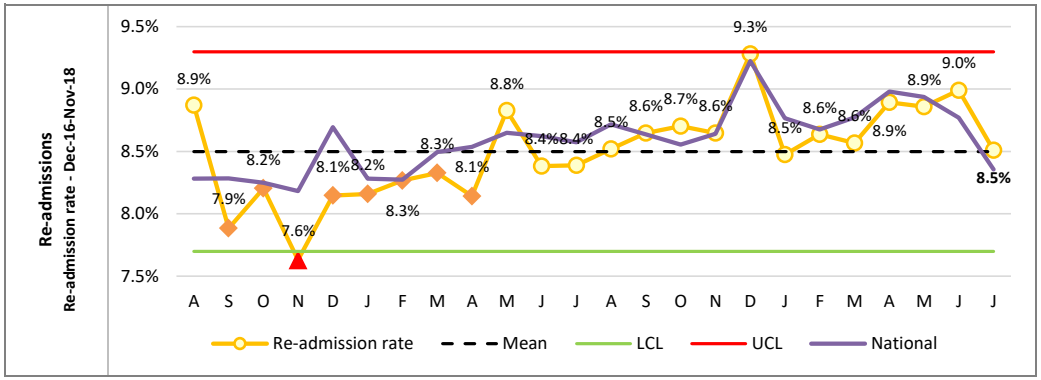

SHMI Rolling 12-months - published quarterly
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2015-16
2016-17
2017-18
2018-19
SHMI quarterly
Standard (100)


SHMI New methodology (from Jan-19)
Jun-14 Sep-14 Dec-14 Mar-15 Jun-15 Sep-15 Dec-15 Mar-16 Jun-16 Sep-16 Dec-16 Mar-17 Jun-17 Sep-17 Dec-17 Mar-18 Jun-18 Sep-18 Dec-18 Mar-19
SHMI
Standard (100)

Effective Services

East and North Hertfordshire NHS Trust

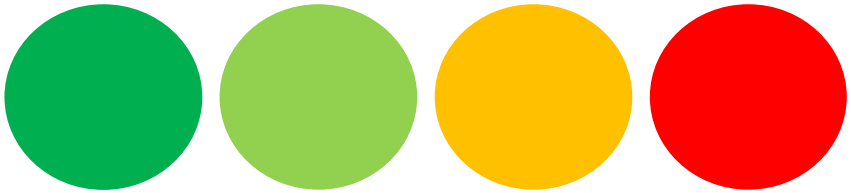




End of Life Care	Proportion of patients with whom their preferred place of death was discussed	tbc	To be confirmed	
	Individualised care pathways	tbc		

Responsive Services

Month 06 | 2019-20



Key Issues

A&E
- Performance for the month of September 2019 was 85.07%.
- No 12-hour trolley waits were reported in September.

Cancer Waiting Times
- In August 2019 the Trust achieved 4 out of the 8 national targets for cancer performance.
- The Trust 62-day performance for August 2019 was 73.3%, which is below the revised trajectory of 82.1%.
- The cancer recovery business case is still in process to implement.
- Good progress is being made on the speciality cancer recovery plans, all plans being reviewed and updated weekly. All plans are now on target.
- The capacity challenges with specialist treatments such as Brachytherapy, PET scans and histology, have now been addressed and plans are in place to deliver sufficient capacity to deliver Trust's 62-day performance.
- Commitment has been obtained from IMAS to support the Trust with ongoing work with:
  - Critical review of service specific MDT and PTL meetings with written feedback;
  - Histology Demand & Capacity model has been completed and awaiting final report from IST. Pathway analysis for Histology services in process to be completed;
  - Continue to Work to deliver the 28-day faster diagnosis target, which is currently at 51.4% compliance;
  - Development of metrics to demonstrate improvements in the performance whilst working to delivery of recovery trajectory. Current analysis shows a statistically significant improvement in the Trust 62-day compliance from April to August 2019.

RTT
- Incomplete performance for September was 84.83%, slightly lower than the 85.18% reported in August.
- The August backlog was 6,929 a slight increase of increase of 7 from August.
- There were 18 52-week breaches reported in our September incomplete position, a slight reduction from 21 in August.

Diagnostics
- DM01 performance for September is 0.22% against the national standard of 1% and the August position of 0.63%.

Stroke
- Performance for September 79.7% Improvement from August performance.
- 4 hr target taking into account the exclusion of the Inter hospital transfer and inpatient stroke – September 2019 81.5%.
- Training being arranged with ED doctors, to ensure that there is early escalation and referrals are being made to the Stroke team.
- Thrombolysis rate at 9.7% continuous reduction on previous months. Audit to be undertaken to review the reason for the decline in performance. Stroke Nurses commenced delivery of training to the Ambulance Crew, with the aim to help with early attendance to A&E within onset time, which has an impact on the achievement of the Target if delays to arrival to hospital.
- Ongoing significant improvement in 60-min to scan performance. Due to the implementing of the Stroke Nurses requesting scans at time of arrival in A&E – 58.3% performance for September 2019.
- Table above now showing the 28.6% of thrombolysis received in less than 60 minutes as this is the gold standard, however up to 4.5hrs from onset time is NICE guidance approved. This has an impact on the arrival time to the Trust
- Maintain performance of meeting of 40% target for ESD performance at 50.9% for September 2019.
- TIA performance within 24-hrs significantly; review of the national reporting requirements to ensure we are adhering and reporting as per national requirements. As from September we will have Project lead who will focus on the TIA element of the Stroke performance and the implementing and updating of processes in-line with NICE Guideline published in May - which is currently a Gap analysis is being undertaken.
- Charing Cross Thrombectomy pathway from 19th August will be 24/7.

Executive Response

A&E
- The trust ED performance in September was 85.07%. September was a particularly challenging month in relation to demand on emergency services with type 1 attendances up by >2% compared to August and >5% compared to September 2018. In response to the increasing demand we continue to improve triage processes to ensure that we optimise opportunities to redirect patients to alternative pathways.
- To continue to demonstrate our commitment to improving ambulance arrival to handover times the trust has agreed to a more aggressive improvement trajectory commencing November 2019. This includes a zero tolerance for delays of over 60minutes. One of the key will include direct referral to frailty from ambulance trolley.
- The emergency department management team at ENHT attended the GIRFT workshop in early October. The data presented demonstrates that as a Trust ENHT featured in the top 50% trusts regionally on a majority of metrics. However, the data also highlights a number of opportunities to improve flow and one key area the Trust is keen to focus on is the number of patients discharged, transferred or admitted within 2 hours of arrival to our emergency department through ensuring optimal use of same day emergency care pathways.

Cancer performance (August)
- In August 2019, the Trust achieved 4 of the 8 national targets for cancer performance: 2ww and 31 -day 1st definitive treatment, 31-day subsequent for Radiotherapy and Chemotherapy. Cancer performance is available one month in arrears.
- The Trust has always previously delivered against the national standard which requires 93% of patients referred on a two -week pathway by their GP to have attended the 1st Outpatient appointment within 14 days. For August 2019 the Trust performance was 94.8% which equates to 1312 out of 1384 pathways meeting the two -week standard, with 72 breaches of the standard being reported.
- In August 2019, the Trust wide average days wait for first appointment is at 10 days and the majority of patients were seen between 8 and 12 days.
- The Trust performance for 31-day to first definitive treatment was 97.0% which equates to 224 out of 231 pathways meeting the 31-day standard, with 7 breaches of the standard reported. The standard requires 96% of patients to receive treatment within 31 days of diagnosis. This was the second time in 6 months since the Trust last met this standard.
- In August 2019 the Trust performance for the Faster Diagnosis is 51.4% for the 2ww patients and 41.5% for the screening patients.
- Reported 62-day performance for August 2019 was 73.3%, which is 8.8% below the revised recovery trajectory of 82.1%. 2 out of 10 tumour sites met the standard with 35% of the breaches belonging to Urology.

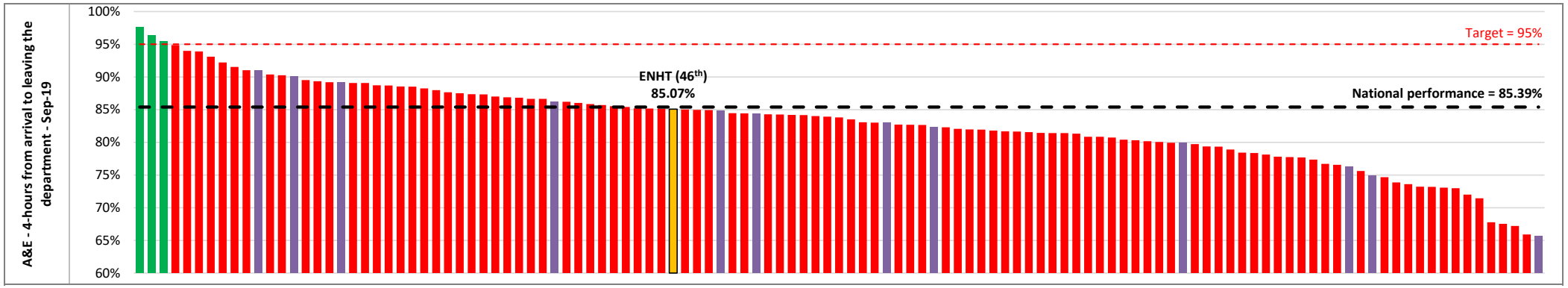
RTT
- Performance has worsened slightly in September and is below our trajectory of 89.5%. Backlog pressures in the T&O, Oral and Gastroenterology specialties are hampering the Trust's progress towards RTT compliance. A plan and improvement trajectory is being developed for Oral, T&O, Gastroenterology to reduce the number of patients in the back log and improve overall RTT compliance.
- The Trust reported 18 52-week breaches. Patients in the following specialities waited over 52 weeks - T&O, Oral, Gastroenterology, Ophthalmology & ENT. Tracking of individual patients continues for all those over 40 weeks. Operational grip within Surgery is improving, all patients at risk of breaching 52 -weeks in October, November have a clock stop (treatment) or next event planned. Outcomes are tracked daily and patients waiting over 52 weeks have a harm review completed. A significant drop in 52-week breaches is expected by the end of October.

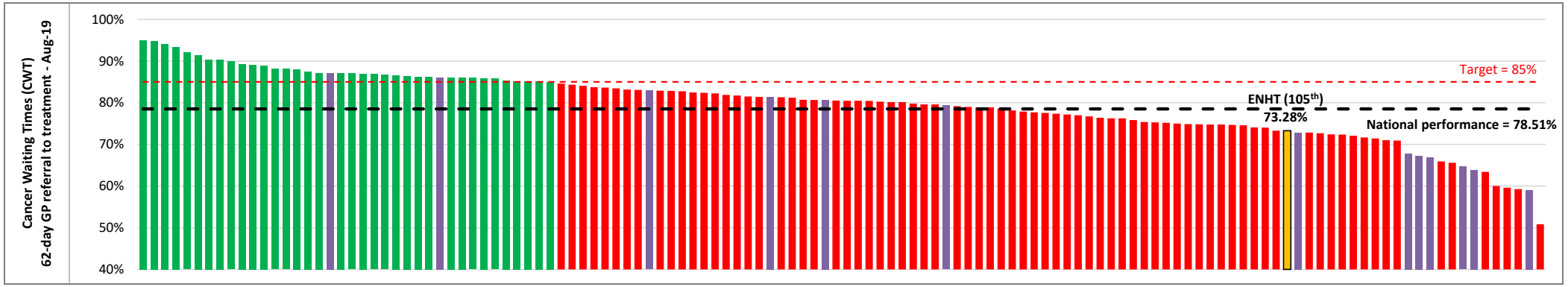
Diagnostics
- Diagnostics performance in September remains compliant at 0.22%. 9 patients waited more than 13 weeks for a diagnostic test in September. The elimination of 13 -week breaches in diagnostic services is our current priority whilst maintaining the compliant position overall.

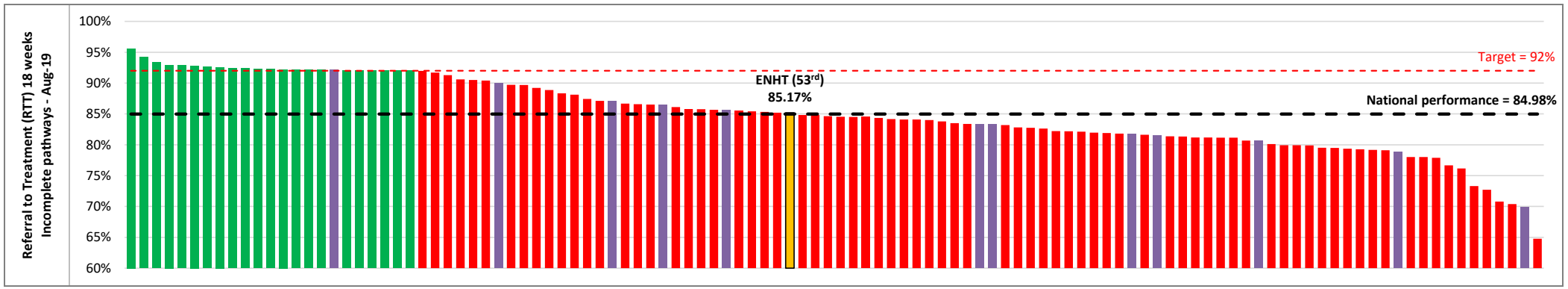
Responsive Services

Trust performance against all Trusts nationally

East and North Hertfordshire NHS Trust



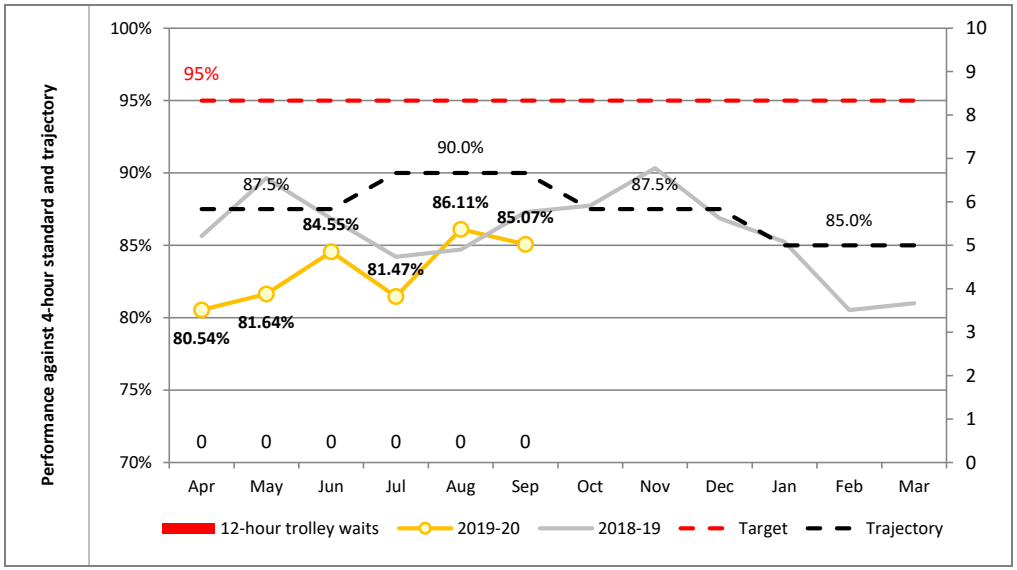




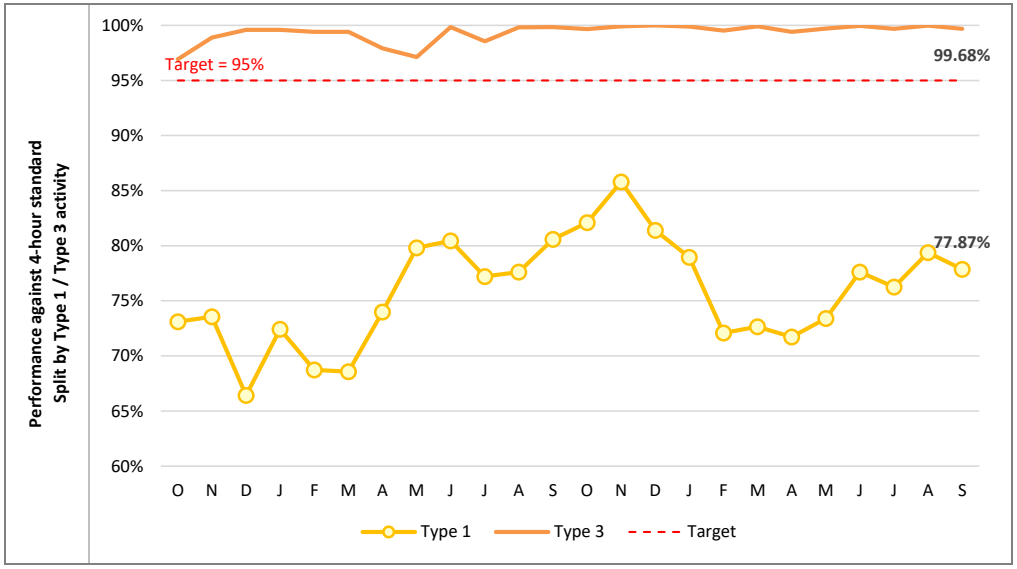
Responsive Services

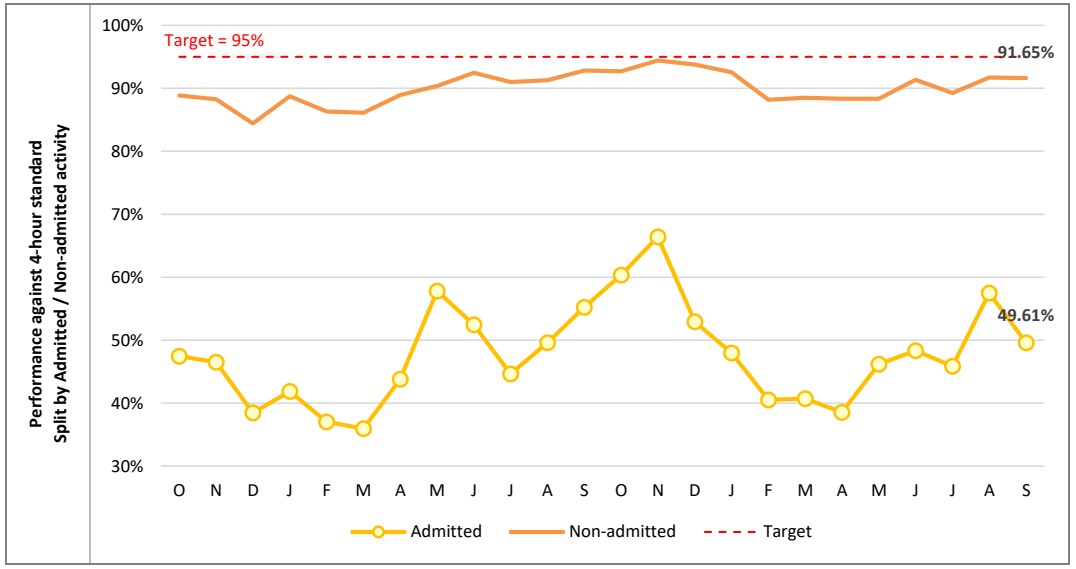
Emergency Department Performance

East and North Hertfordshire NHS Trust



Domain	Metric	Target	Aug-19	Sep-19	Change	Trend
Other Emergency Department measures	Ambulance handovers Proportion within 15 minutes	-	48%	53%	▲	
	Ambulance handover breaches 30-minutes	230	180	227	▲	
	Ambulance handover breaches 60-minutes	43	22	57	▲	
	Attendance to admission conversion rate	-	34.4%	35.4%	▲	
	Time to initial assessment 95th centile	15	58	66	▲	
	Time to treatment Median	60	68	68	◀▶	
	Left department before being seen for treatment	5%	1.8%	1.9%	▲	
	Unplanned re-attendance rate	5%	4.4%	4.6%	▲	





Responsive Services

Cancer Waiting Times

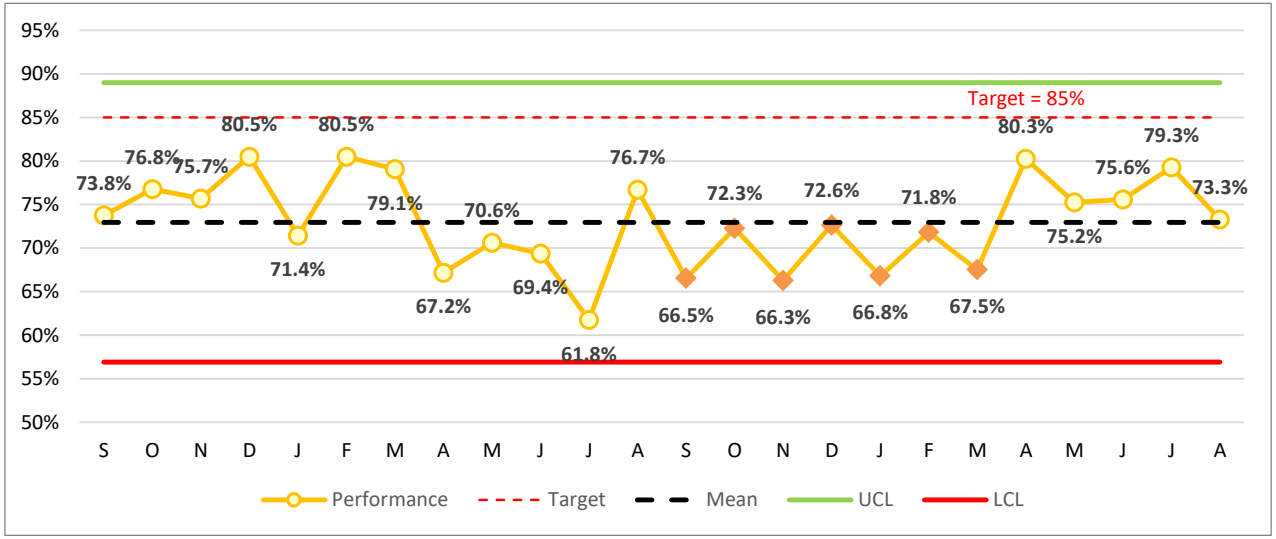
East and North Hertfordshire NHS Trust

12-months' performance - all standards

Standard	Target	2018-19								2019-20					
		Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD	Apr-19	May-19	Jun-19	Jul-19	Aug-19	YTD
Two week waits Suspected cancer	93%	92.6%	97.1%	96.7%	97.2%	95.6%	96.6%	97.0%	94.8%	95.9%	95.6%	96.7%	96.1%	94.8%	95.8%
Two week waits Breast symptomatic	93%	88.8%	94.9%	94.4%	93.4%	94.5%	94.0%	94.0%	92.6%	88.7%	92.7%	93.4%	94.8%	87.3%	91.1%
31-day First definitive treatment	96%	95.3%	93.8%	91.8%	96.3%	96.0%	95.1%	94.5%	93.9%	93.5%	94.9%	91.9%	97.0%	97.0%	94.8%
31-day subsequent treatment Anti-cancer drugs	98%	100.0%	99.4%	97.99%	100.0%	98.7%	99.4%	98.3%	99.0%	98.2%	97.8%	99.3%	99.1%	99.4%	98.7%
31-day subsequent treatment Radiotherapy	94%	97.6%	97.9%	97.3%	97.2%	95.0%	98.0%	95.7%	95.1%	96.9%	98.3%	98.9%	96.3%	97.5%	97.5%
31-day subsequent treatment Surgery	94%	57.1%	74.2%	69.4%	84.2%	63.6%	76.5%	78.8%	75.6%	96.8%	80.0%	78.9%	77.4%	83.3%	83.3%
62-day GP referral to treatment	85%	66.5%	72.3%	66.3%	72.6%	66.8%	71.8%	67.5%	69.1%	80.3%	75.2%	75.6%	79.3%	73.3%	76.7%
62-day Specialist screening service	90%	87.5%	74.2%	86.2%	100.0%	72.7%	79.2%	95.2%	79.6%	81.8%	100.0%	63.6%	56.0%	82.4%	77.0%

62-day GP referral to treatment Aug-19

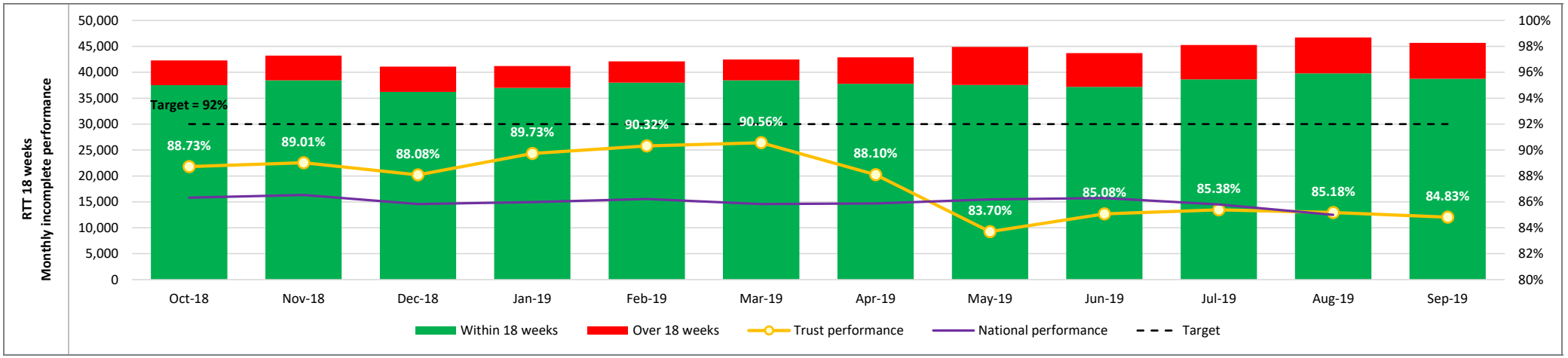
Tumour Site	OK	Breach	Total	Perf.
Breast	18.5	4.0	22.5	82.2%
Gynaecology	7.5	1.5	9.0	83.3%
Haematology	4.0	2.0	6.0	66.7%
Head and Neck	4.5	3.0	7.5	60.0%
Lower GI	6.0	2.0	8.0	75.0%
Lung	3.5	3.5	7.0	50.0%
Other	2.5	0.0	2.5	100.0%
Sarcoma	0.0	0.0	0.0	-
Skin	23.0	4.5	27.5	83.6%
Testicular	0.0	0.0	0.0	-
Upper GI	6.5	4.5	11.0	59.1%
Urology	20.0	10.0	30.0	66.7%
Total	**96.0**	**35.0**	**131.0**	**73.3%**



Responsive Services

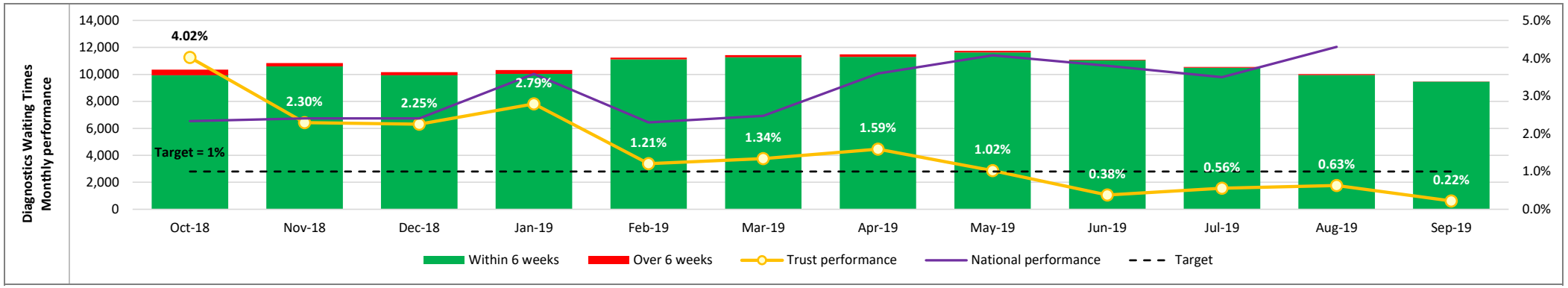
RTT 18 weeks

East and North Hertfordshire NHS Trust



RTT 18 weeks
In-month performance by Specialty - Sep-19

Specialty	Clock Stops - Admitted			Clock Stops - Non-admitted			Incomplete pathways						Clock Starts
	Total	Performance	Over 52 weeks	Total	Performance	Over 52 weeks	Within 18 weeks	Over 18 weeks	Total	Performance	Over 40 weeks	Over 52 weeks	
General Surgery	254	77.95%	0	308	87.99%	0	2,452	342	2,794	87.76%	11	0	895
Urology	176	74.43%	0	394	91.12%	0	1,891	239	2,130	88.78%	2	0	723
Trauma & Orthopaedics	100	52.00%	0	801	81.77%	0	2,641	676	3,317	79.62%	73	8	861
Ear, Nose & Throat (ENT)	169	67.46%	0	620	89.68%	0	2,589	244	2,833	91.39%	7	2	935
Ophthalmology	156	57.69%	0	606	86.30%	0	3,705	323	4,028	91.98%	9	1	1,308
Oral Surgery	71	9.86%	0	318	45.60%	0	1,766	812	2,578	68.50%	37	2	448
Plastic Surgery	125	78.40%	0	777	94.34%	0	1,596	83	1,679	95.06%	2	0	947
Cardiothoracic Surgery	0	-	0	13	92.31%	0	31	1	32	96.88%	1	0	15
General Medicine	4	100.00%	0	163	100.00%	0	1,158	3	1,161	99.74%	0	0	479
Gastroenterology	399	77.19%	0	330	55.45%	0	2,549	736	3,285	77.60%	31	1	891
Cardiology	67	88.06%	0	595	71.26%	0	2,145	556	2,701	79.42%	3	0	799
Dermatology	0	-	0	325	84.00%	0	978	160	1,138	85.94%	5	0	377
Thoracic Medicine	36	91.67%	0	301	82.06%	0	1,135	150	1,285	88.33%	6	0	430
Neurology	0	-	0	329	89.06%	0	1,281	106	1,387	92.36%	3	0	416
Rheumatology	1	100.00%	0	167	61.68%	0	890	233	1,123	79.25%	2	0	207
Geriatric Medicine	1	0.00%	0	77	94.81%	0	129	2	131	98.47%	0	0	63
Gynaecology	81	71.60%	0	365	87.40%	0	2,672	313	2,985	89.51%	21	0	989
Other	151	57.62%	0	2,888	84.90%	0	9,124	1,950	11,074	82.39%	115	4	3,818
Total	**1,791**	**69.24%**	**0**	**9,377**	**83.01%**	**0**	**38,732**	**6,929**	**45,661**	**84.83%**	**328**	**18**	**14,601**

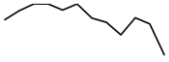
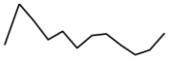


Diagnostics Waiting Times In-month performance by Modality - Sep-19	Category	Modality	Within 6 weeks	Over 6 weeks	Total	Performance	13+ weeks
	Imaging	Magnetic Resonance Imaging	1,265	2	1,267	0.16%	0
		Computed Tomography	873	0	873	0.00%	0
		Non-obstetric ultrasound	4,278	5	4,283	0.12%	0
		DEXA Scan	421	0	421	0.00%	0
	Physiological Measurement	Audiology - audiology assessments	43	0	43	0.00%	0
		Cardiology - echocardiography	1,094	4	1,098	0.36%	2
		Neurophysiology - peripheral neurophysiology	151	1	152	0.66%	0
		Respiratory physiology - sleep studies	141	0	141	0.00%	0
		Urodynamics - pressures & flows	74	6	80	7.50%	6
	Endoscopy	Colonoscopy	501	1	502	0.20%	0
		Flexi sigmoidoscopy	190	0	190	0.00%	0
		Cystoscopy	73	0	73	0.00%	0
		Gastroscopy	355	2	357	0.56%	1
	Total		**9,459**	**21**	**9,480**	0.22%	9

Responsive Services

Stroke Services

East and North Hertfordshire NHS Trust

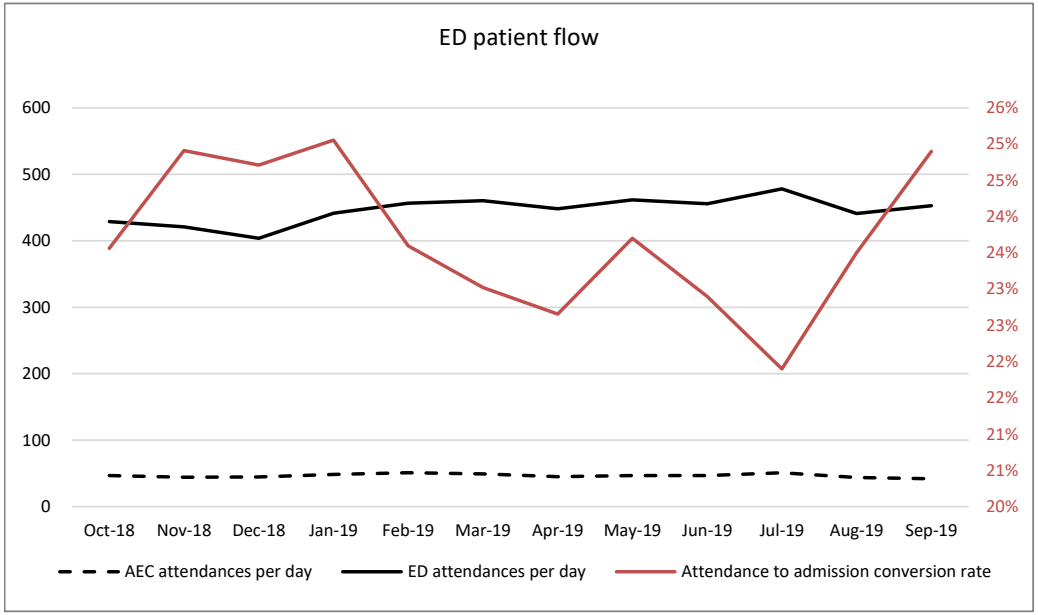
Domain	Metric	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Trend
Stroke	Trust SSNAP grade	A	A	A	A	A	A	A	A	A	A	tbc	tbc	tbc	
	Discharged with AF on anticoagulants	80%	88.9%	80.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	77.8%	100.0%	100.0%	
	4-hours direct to Stroke unit from ED	90%	75.9%	73.0%	75.4%	69.6%	69.0%	72.1%	50.0%	59.3%	72.1%	63.3%	64.5%	79.7%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	90%	75.9%	72.9%	76.1%	71.0%	72.7%	75.4%	54.2%	60.0%	71.7%	65.1%	64.5%	81.5%	
	Number of confirmed Strokes in-month on SSNAP	-	57	64	70	70	73	71	66	86	66	67	68	72	
	Proportion of patients spending 90% of time on the Stroke unit	80%	92.7%	88.9%	95.7%	95.7%	93.1%	88.4%	90.8%	94.0%	92.1%	87.7%	98.4%	91.4%	
	60-minutes to scan from time of arrival	50%	57.9%	54.0%	57.1%	50.0%	61.6%	45.6%	56.1%	53.5%	53.0%	53.7%	61.8%	58.3%	
	Scanned within 12-hours - all Strokes	100%	98.2%	93.7%	97.1%	100.0%	98.6%	98.6%	97.0%	98.8%	92.4%	97.0%	100.0%	95.8%	
	Total Thrombolysis rate for confirmed Strokes	11%	7.0%	14.3%	8.6%	10.0%	12.3%	8.5%	4.5%	14.3%	15.6%	13.4%	8.8%	9.7%	
	Thrombolysed within 60-minutes of arrival	-	25.0%	33.3%	n/a	42.9%	22.2%	16.7%	33.3%	50.0%	70.0%	66.7%	50.0%	28.6%	
	Discharged with JCP	80%	94.6%	97.6%	100.0%	100.0%	97.9%	100.0%	95.1%	93.7%	89.5%	95.3%	93.2%	82.7%	
	Discharged with ESD	40%	45.9%	64.4%	56.8%	48.1%	51.9%	44.4%	50.0%	50.8%	45.6%	41.3%	43.5%	50.9%	

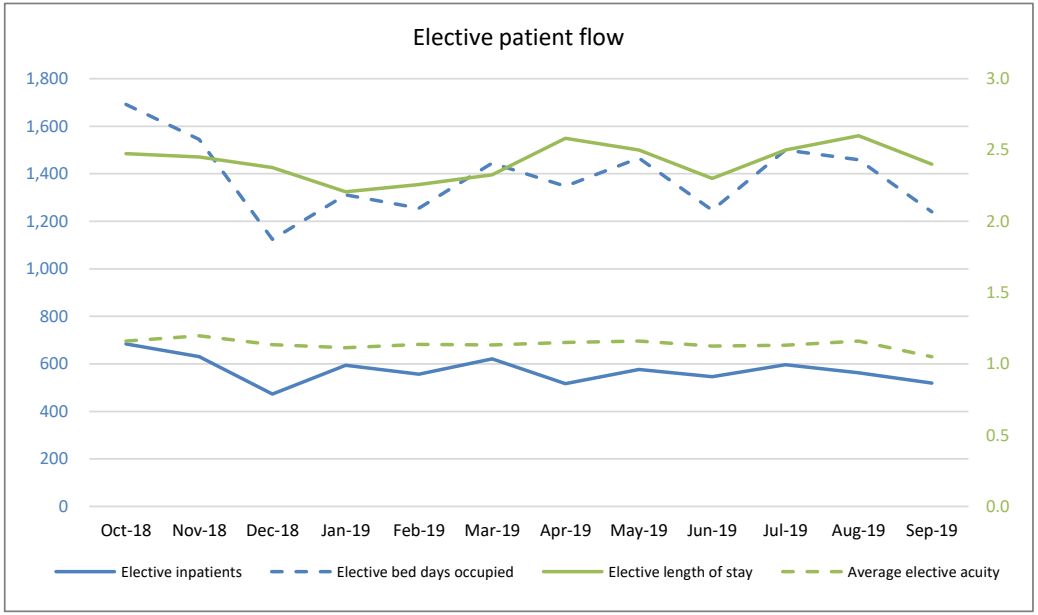
Responsive Services

East and North Hertfordshire NHS Trust

Patient Flow

Domain	Metric	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Trend
Emergency Department Flow Indicators	A&E & UCC attendances	13,297	12,627	12,517	13,690	12,788	14,266	13,440	14,306	13,675	14,821	13,676	14,041	
	Attendance to admission conversion rate	23.6%	24.9%	24.7%	25.1%	23.6%	23.0%	22.7%	23.7%	22.9%	21.9%	23.5%	24.9%	
	ED attendances per day	429	421	404	442	457	460	448	461	456	478	441	453	
	AEC attendances per day	47	44	45	49	51	49	45	47	47	51	44	42	
	4-hour target performance %	87.8%	90.3%	86.9%	85.2%	80.5%	81.0%	80.5%	81.6%	84.6%	81.5%	86.1%	85.1%	
	Time to initial assessment 95th centile	57	57	59	58	60	75	64	69	62	74	58	66	
	Ambulance handover breaches 30-minutes	491	247	373	516	597	606	480	368	262	336	180	227	

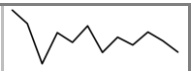
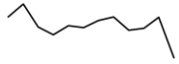
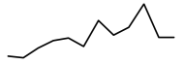
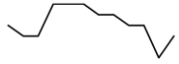
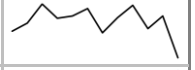




Responsive Services

Patient Flow

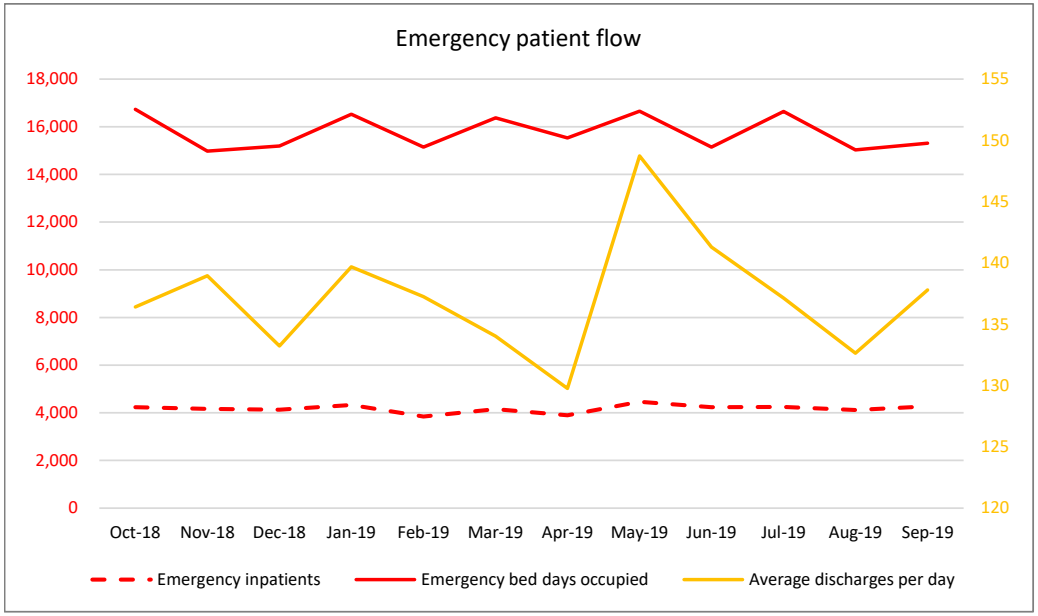
East and North Hertfordshire NHS Trust

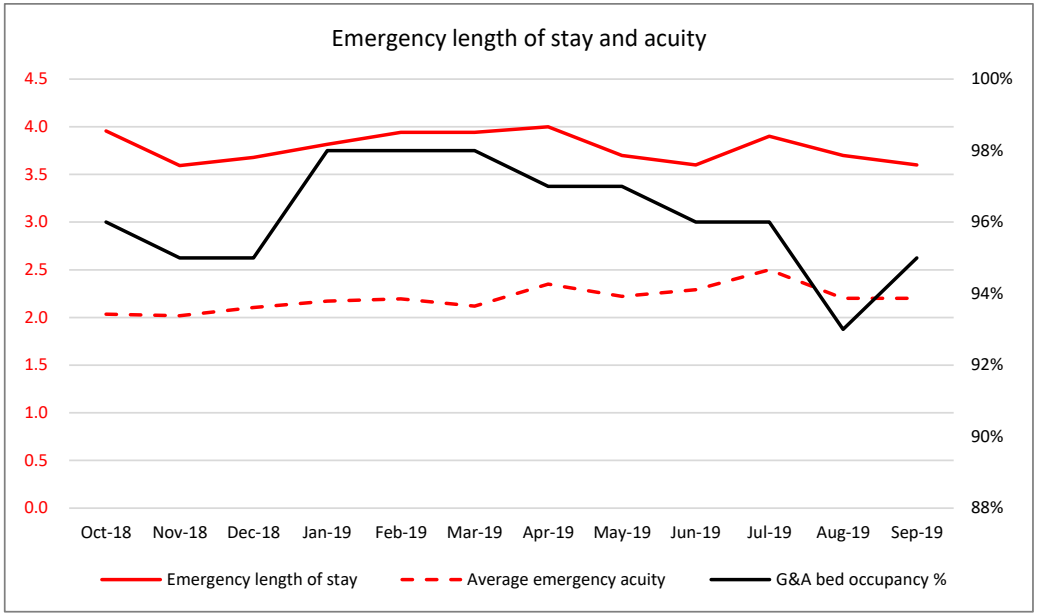
Domain	Metric	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Trend
Elective Inpatient Flow Indicators	Elective inpatients	684	630	473	594	556	621	517	577	546	597	563	519	
	Elective bed days occupied	1,692	1,544	1,124	1,311	1,255	1,445	1,348	1,466	1,247	1,500	1,459	1,240	
	Elective length of stay	2.5	2.5	2.4	2.2	2.3	2.3	2.6	2.5	2.3	2.5	2.6	2.4	
	Daycase rate %	84.0%	84.4%	86.0%	86.0%	84.8%	84.0%	86.8%	86.5%	87.2%	86.7%	86.1%	87.4%	
	Average elective acuity	1.16	1.20	1.13	1.11	1.14	1.13	1.15	1.16	1.13	1.13	1.16	1.05	
Emergency Flow Indicators	Emergency inpatients	4,229	4,169	4,130	4,330	3,843	4,155	3,893	4,462	4,239	4,251	4,112	4,272	
	Average discharges per day	136	139	133	140	137	134	130	149	141	137	133	138	
	Emergency bed days occupied	16,732	14,979	15,192	16,528	15,146	16,380	15,538	16,653	15,153	16,643	15,030	15,312	
	Emergency length of stay	4.0	3.6	3.7	3.8	3.9	3.9	4.0	3.7	3.6	3.9	3.7	3.6	
	Average emergency acuity	2.0	2.0	2.1	2.2	2.2	2.1	2.4	2.2	2.3	2.5	2.2	2.2	
	G&A bed occupancy %	96%	95%	95%	98%	98%	98%	97%	97%	96%	96%	93%	95%	
	Patients discharged via Discharge Lounge	198	195	141	180	189	186	197	225	224	302	406	432	
	Discharges before midday	14.7%	14.6%	14.6%	14.7%	14.4%	14.2%	13.3%	13.1%	13.8%	13.6%	12.5%	12.7%	
	Weekend discharges	13.8%	14.8%	17.2%	15.4%	15.7%	16.6%	13.6%	15.5%	17.0%	14.1%	15.7%	10.5%	
	Proportion of beds occupied by patients with length of stay over 14 days	20.1%	17.9%	18.7%	18.5%	19.6%	18.5%	17.5%	17.8%	16.9%	20.2%	18.1%	20.3%	
	Proportion of beds occupied by patients with length of stay over 21 days	10.7%	9.4%	10.0%	9.2%	10.7%	10.2%	9.3%	9.7%	8.4%	11.1%	10.2%	11.1%	

Responsive Services

East and North Hertfordshire NHS Trust

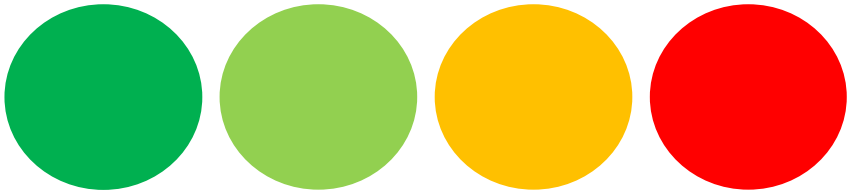
Patient Flow





Well-led Services

Month 06 | 2019-20



Key Issues

Staffing and Pay bill

- The Trust is £2m over the pay budget year-to-date.
- Overall staff utilised including bank and agency decreased by 56 WTE
- Actual pay expenditure was £0.2m lower in M6 due to a decrease in agency costs.
- Agency expenditure decreased by £171k, this meant that the Trust was under the agency ceiling by £91k in month.
- The Trust is over the agency ceiling target by £108k over the year to date.
- There is a 1.3% improvement on turnover compared to the same month the previous year, however, month on month there has been a slight increase to 12.8% (from 12.5%).

Sickness Absence

- Overall sickness absence rate increased by 0.4% to 4.3%, which is higher than the same month the previous year.

Training & Development

- Appraisal compliance decreased from 87.2% to 86.3%, against a target of 90%.
- 9 out of the 15 mandatory training modules are on target and overall compliance remained at 89%.

Executive Response

Overall temporary staffing demand reduced by 3% compared to M5, most notably within Doctors (19%) and Support Services (9%) and A&C (7%). Medical temporary staffing spend reduced by £157k. This is mostly driven by the reduction of vacancies in key areas, specifically A&E and Anaesthetics. Active work continues with reducing agency breaches going into M7. A letter signed by the CPO, FD and MD will be sent to all framework Medical agencies stating that from 4th November, only CVs put forward under the East of England rate will be accepted. Encouragingly, 4 of the 10 remaining high cost agency locums are expected to reduce to the East of England cap rate by the end October. Direct Engagement (DE) is not progressing at the expected rate since moving the supplier to NHSP in July, however there has been month on month improvement in uptake. NHSP Bank Only Locums will go-live on 21st October which will add a further 10 locums for DE savings.

N&M temporary staffing demand increased by 4% due to activity increases within Discharge Lounge (escalation), 5B and ITU. The plans set out earlier in the year for nursing recruitment for 19/20 are now complete, with all 41 of the planned international nurses already commenced. However, a further 9 are planned to commence in month 8 to support winter pressures, with 7 of those being placed in Elderly Care. The reduction in overseas recruitment has resulted in an increased investment in domestic recruitment and retention using a variety of initiatives including interest free loans for visa renewals, a focussed and enhanced offer for current third year student nurses and a band 5 internal transfer scheme. The Trust's attendance at the RCN Jobs Fair in month 9 resulted in over 200 leads which have been followed up and several open days arranged. Recruitment open days continue to run monthly, as well as service specific open days.

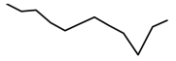
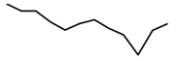
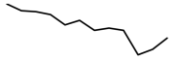
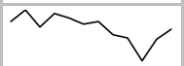
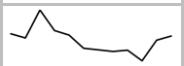
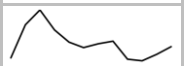
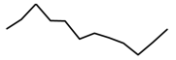
There has been a 0.4% or an additional 384 days lost compared to last month. While this is a normal trend for the start of the school year, this is an increase on last year of 0.3% or 800 days. Surgery division had the largest month on month increase. In response to this, sickness absence oversight clinics have now been established, which is increasing scrutiny of absence and ensuring effective wellbeing management. Analysis highlights that unqualified nursing is a significant outlier compare to other staff groups. Bespoke interventions are being developed with the HRBPs and ERAS team to address this trend.

A staff experience group is now in place focusing on all area impacting on staff retention. The group provides oversight of the development of the just and learning culture, monitors outputs of action plans for surveys works on improvement of services including appraisal, induction and mandatory training.

Well-led Services

Workforce and Staff Development

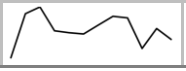
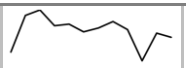
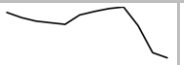
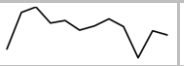
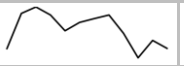
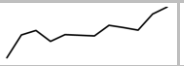
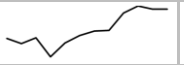
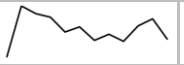
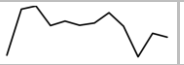
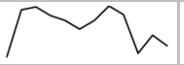
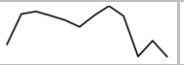
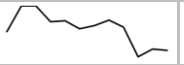
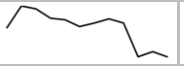
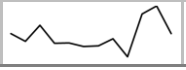
East and North Hertfordshire NHS Trust

Domain	Metric	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Trend	Plan YTD	Actual YTD	Var YTD
Staffing	Approved Budget Establishment WTEs	5,915	5,912	5,912	5,923	5,927	5,927	6,089	6,074	6,083	6,100	6,132	6,134		6,134	6,134	0
	Permanent Staffing WTEs Utilised	5,052	5,084	5,084	5,077	5,114	5,123	5,185	5,245	5,248	5,276	5,309	5,271		5,811	5,271	-540
	Bank Staffing WTEs Utilised	508	473	435	485	495	566	482	510	493	516	502	497		294	497	203
	Agency Staffing WTEs Utilised	130	115	99	118	114	114	98	113	104	106	100	87		29	87	59
	Gap - Budget WTEs & Permanent WTEs	864	829	828	845	812	804	904	829	836	824	823	863		323	863	540
	Gap Permanent Utilised / Budget WTEs	14.6%	14.0%	14.0%	14.3%	13.7%	13.6%	14.8%	13.6%	13.7%	13.5%	13.4%	14.1%		6.0%	13.9%	7.9%
	Recruitable Vacant Posts	460	441	445	413	393	410	427	406	387	333	403	419		473	419	-54
	Vacancy Rate	8.1%	7.8%	7.8%	7.3%	6.9%	7.2%	7.4%	7.0%	6.7%	5.8%	6.9%	7.2%		8.1%	7.2%	-0.9%
	Turnover Rate	13.8%	13.6%	13.5%	13.5%	13.2%	13.3%	13.0%	13.1%	13.0%	12.3%	12.5%	12.8%		12.0%	12.8%	0.8%
Sickness	Sickness FTE Days Lost	7,293	7,477	8,189	7,832	6,845	6,835	6,778	6,346	6,054	6,299	6,522	6,871		37,690	38,869	1,179
	Short term sickness rates %	2.2%	2.5%	2.1%	2.4%	2.3%	2.1%	2.2%	1.8%	1.8%	1.1%	1.7%	2.0%		2.1%	1.8%	-0.4%
	Long term sickness rates %	2.3%	2.2%	2.7%	2.4%	2.3%	2.0%	2.0%	2.0%	2.0%	1.8%	2.2%	2.3%		2.2%	2.0%	-0.1%
	Sickness Rate	4.5%	4.8%	5.1%	4.8%	4.6%	4.2%	4.2%	3.8%	3.8%	3.7%	3.9%	4.3%		3.4%	3.9%	0.5%
	Staff on long term sick headcount	124	139	159	121	122	111	109	109	109	95	122	100		120	107	-12
	Maternity % Headcount	2.2%	2.4%	2.4%	2.3%	2.3%	2.3%	2.3%	2.3%	2.2%	2.2%	2.2%	2.3%		2.2%	2.2%	0.0%
	Nursing (Q & U) sickness rate	5.0%	5.3%	5.8%	5.3%	5.3%	4.7%	4.9%	4.7%	4.6%	4.2%	4.6%	5.0%		5.2%	4.7%	-0.5%
	Nursing (Q & U) sickness days lost in month	3,376	3,461	3,900	3,559	3,226	3,190	3,216	3,244	3,040	2,890	3,145	3,264		20,079	18,800	-1,279

Well-led Services

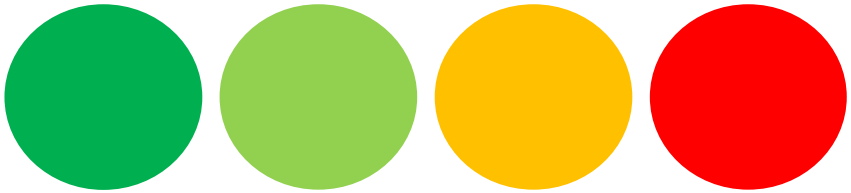
Workforce and Staff Development

East and North Hertfordshire NHS Trust

Domain	Metric	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Trend	Plan YTD	Actual YTD	Var YTD
Training & Development	Staff Appraised	84%	86%	82%	83%	82%	82%	84%	84%	86%	86%	87%	86%		90%	86%	-4%
	Mandatory Training 100% Compliant	62%	62%	63%	61%	61%	62%	62%	62%	64%	66%	65%	64%		90%	64%	-26%
	Overall Training Compliant	88%	90%	90%	89%	89%	89%	89%	89%	89%	88%	89%	89%		90%	89%	-1%
Statutory and Mandatory Training	Conflict Resolution - 2 Years	91%	93%	93%	92%	93%	92%	92%	93%	92%	91%	92%	92%		90%	92%	2%
	Equality & Diversity	91%	91%	92%	93%	91%	91%	92%	92%	93%	93%	94%	94%		90%	93%	3%
	Equality, Diversity and Human Rights	72%	71%	70%	70%	69%	71%	72%	73%	73%	69%	63%	62%		90%	69%	-21%
	Fire Safety	84%	86%	86%	85%	85%	85%	85%	84%	84%	84%	85%	84%		90%	84%	-6%
	Health and Safety	91%	93%	93%	92%	93%	92%	92%	93%	92%	91%	92%	92%		90%	92%	2%
	IPC - Clinical 2 yr	90%	92%	93%	92%	91%	92%	92%	92%	91%	90%	91%	90%		90%	91%	1%
	IPC - Non-Clinical 2 yr	91%	93%	93%	92%	93%	93%	93%	93%	93%	93%	94%	94%		90%	93%	3%
	Data security awareness	71%	70%	71%	68%	71%	72%	73%	73%	76%	77%	76%	76%		90%	75%	-15%
	Moving & Handling for People Handlers	91%	94%	94%	94%	93%	93%	92%	92%	92%	93%	93%	92%		90%	92%	2%
	Moving and Handling	92%	94%	94%	93%	93%	93%	93%	94%	93%	92%	93%	93%		90%	93%	3%
	Safeguarding Adults Level 1	89%	91%	91%	90%	90%	90%	90%	91%	90%	89%	90%	89%		90%	90%	0%
	Safeguarding Adults Level 2	88%	90%	90%	90%	90%	89%	90%	90%	90%	87%	88%	87%		90%	89%	-1%
	Safeguarding Children Level 1	92%	94%	94%	93%	93%	92%	92%	93%	92%	90%	91%	91%		90%	92%	2%
	Safeguarding Children Level 2	92%	94%	93%	93%	92%	92%	92%	92%	92%	89%	90%	89%		90%	91%	1%
	Safeguarding Children Level 3	89%	88%	90%	88%	88%	87%	87%	88%	86%	92%	93%	89%		90%	89%	-1%

Sustainable Services

Month 06 | 2019-20



Key Issues

- The Trust's reported position at Month 6 is a deficit of £3.4m. Exclusive of donated asset and profit on land sale impacts the deficit is £4.6m. This remains in line with the control total plan for 19/20.
- The reported M6 deficit includes the expected receipt of PSF & FRF performance incentive funds totalling £5.7m. Payment of these funds is confirmed by NHSI on a quarterly basis upon the achievement of underlying financial achievement targets. Based upon M6 results the Trust presently envisages full receipt of these funds across the financial year.
- At M6 the Trust reports an over achievement (£5.7m) against SLA contracts with its commissioners. The majority of the YTD income overachievement is driven by above plan emergency activity. Joint review and analysis of this position by the Trust and its host CCG indicates that this over performance and activity growth has been driven by a number of factors but the most significant elements are:
  - The emergency plan was not a true reflection of the 18/19 outturn run rate.
  - A very significant shortfall in the impact of CCG QIPP schemes.
  - Unprecedented levels of demand growth in areas experiencing high rates of housing growth.
  - Increasing volumes of patients directly routed to the Trust ED from primary care and NHS111, combined with an increase in care home activity.
- The 19/20 SLA contract for emergency activity incorporates a blended payments mechanism that applies marginal rates to over performance within agreed bands. M6 performance is after the application of these rules.
- The much higher levels of emergency activity that continue to present at the Trust whilst resulting in higher levels of income have however been matched by much higher pay and cost requirements as the Trust has needed to keep open capacity that it had reasonably expected would be closed as a result of QIPP schemes and indeed has needed to incur further escalation costs beyond this level. As such Pay budgets report a significant YTD overspend of £4.8m.
- Performance against medical staffing budgets remain a key concern, reporting an overspend of £1.7m across the YTD. The bulk of this pressure is driven by two separate issues (1) the use of above plan levels of WLIs in Surgery to deliver the 19/20 activity plan as opposed to achieving improved levels of theatre and outpatient efficiency and (2) significant challenges in reducing reliance on high cost locum staff particularly within Surgery.
- The pay position has been further compounded by significant ongoing overspends against nursing budgets, particularly in relation to increased temp staffing use across medical and surgical wards. The roll out of roster training to senior nursing managers remains a key priority.
- Staff used by the Trust to deliver services has increased significantly year on year. An additional 165 WTE's were used in Sept 19 compared with 12 months earlier (excluding the impact of Therapies & Pharma). The growth of substantive fill but the failure to commensurately reduce temp staffing spend remains a significant concern.
- In the YTD the Trust delivered total CIP's of £7.0m. Whilst high by historical standards this was nevertheless £0.9m less than planned. Key features of this slippage include the non-achievement of planned theatre and outpatient savings targets.

Executive Response

- Key elements of the finance performance represent a significant concern for the Trust. The income over performance YTD largely relates to emergency activity, this is neither operationally sustainable for the Trust or affordable by commissioners. The significant overspend against pay budgets is in large measure driven by the impact of CCG QIPP scheme shortfalls and the consequent need to maintain capacity that has been expected to close.
- The Trust has undertaken through deep dive analysis into the drivers underpinning emergency growth and shared this fully with commissioners, and remains committed to working collaboratively to manage this position.
- In addition, the Trust continues to face challenges in the delivery clinical productivity targets and also weaknesses in the management of medical and nursing temporary staffing costs. This underlying position is not sustainable and requires redress if the Trust is to deliver its 19/20 financial plan.
- The Trust Executive have introduced a number of remedial forecast mitigation work streams in order to support outturn delivery. These include weekly IFD oversight groups for both Medical Staffing and Nursing Management which have been identified as key in maintaining oversight and management of the control environment. The groups are led by Executive Directors and will implement agreed improvement plans for these staffing areas.
- Further IFD work streams have been set up in respect of establishing a high impact focus on Pathology, Pharmacy and Procurement costs in the second half of the year. In addition, the Trust has introduced tighter controls for the review and approval of admin and senior managers temporary staffing costs. Regular reports on the effectiveness of these mitigation programmes will be provided to the Finance and Performance Committee and weekly Executive Committee meetings.
- The Trust continues to expand the scope and sophistication of its BI universe at pace to support the need to supply relevant, timely and accurate data to clinicians and managers to enable more effective decision making and plan delivery. Furthermore, the Trust continues to undertake monthly Accountability Review Meetings (ARM) with division to support improved performance. These meeting contain review of finance delivery and CIP achievement.
- The Trust continues to maintain 'Model Hospital' project working groups, to drive progress across a number of other key clinical processes - i.e. Theatres, Outpatients, Consultant Job Planning as well as Inpatient Flow. The success and achievements of these groups has been extremely variable.
- The Trust also continues to schedule a weekly series of Performance & Activity Meetings (PAM) meetings. Composed of key corporate and operational managers PAM meets to review and track SLA activity delivery and performance against both plan and forecast and agrees remedial action where required.
- The Trust PMO function remains embedded in terms of supporting divisional CIP projects, IFD meetings and activities as well as helping divisions to deliver improvements across key process themes.

Sustainable Services

Finance Plan Performance

East and North Hertfordshire NHS Trust

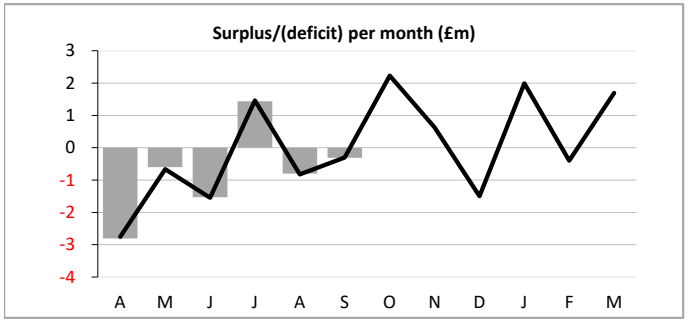
Domain	Metric	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	34.4	33.4	30.4	33.7	30.4	33.3	32.7	35.3	33.5	37.2	34.3	34.3		202.7	207.2	4.5
	Other Income Earned	5.0	5.3	5.1	5.4	4.8	-6.8	3.5	3.7	3.6	3.8	3.7	3.7		24.1	22.1	-2.0
	Pay Costs	23.2	23.2	22.9	23.5	23.2	23.6	24.8	24.8	24.5	24.7	24.5	24.3		145.5	147.5	2.0
	Non Pay Costs inc Financing	17.1	16.6	15.9	14.6	14.6	2.8	15.0	15.6	15.0	16.0	15.3	15.1		91.6	92.0	0.4
	Underlying Surplus / (Deficit)	-0.9	-1.1	-3.3	1.0	-2.7	0.0	-3.6	-1.4	-2.3	0.4	-1.9	-1.4		-10.3	-10.3	0.0
	PSF Earned	0.0	0.0	0.0	0.0	0.0	5.9	0.4	0.4	0.4	0.5	0.5	0.5		2.5	2.5	0.0
	FRF Received	-	-	-	-	-	-	0.5	0.5	0.5	0.6	0.6	0.6		3.2	3.2	0.0
	Retained Surplus / Deficit	-0.9	-1.1	-3.3	1.0	-2.7	6.0	-2.8	-0.6	-1.526	1.4	-0.8	-0.3		-4.6	-4.6	0.0
Paybill Metrics	Substantive Pay Costs	19.6	19.4	19.7	19.9	19.7	19.8	21.2	20.8	20.8	20.8	20.8	20.9		134.3	125.2	-9.1
	Premium Pay Costs Overtime & WLI	0.4	0.4	0.4	0.3	0.4	0.4	0.4	0.5	0.4	0.4	0.4	0.3		2.0	2.3	0.3
	Premium Pay Costs Bank Costs	2.3	2.3	2.0	2.2	2.2	2.5	2.2	2.4	2.2	2.4	2.3	2.2		6.7	13.7	7.0
	Premium Pay Costs Agency Costs	0.9	1.0	0.9	1.0	1.0	1.0	1.0	1.1	1.0	1.1	1.1	0.9		2.4	6.3	3.9
	Premium Pay Costs As % of Paybill	15.3%	16.1%	14.1%	15.3%	15.3%	16.4%	14.5%	16.2%	14.8%	15.8%	15.4%	14.1%		7.7%	15.1%	7.5%

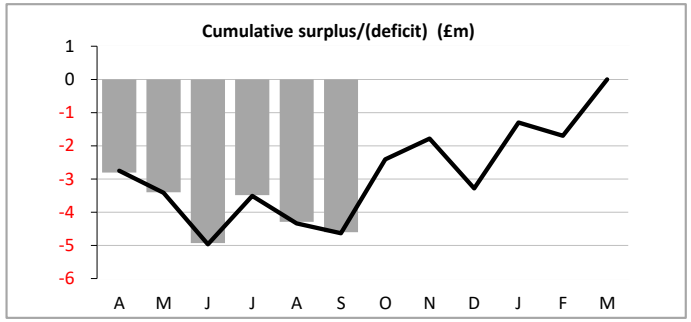
Sustainable Services

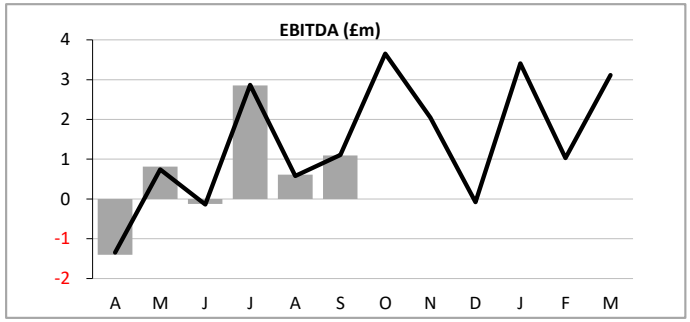
Finance Plan Performance

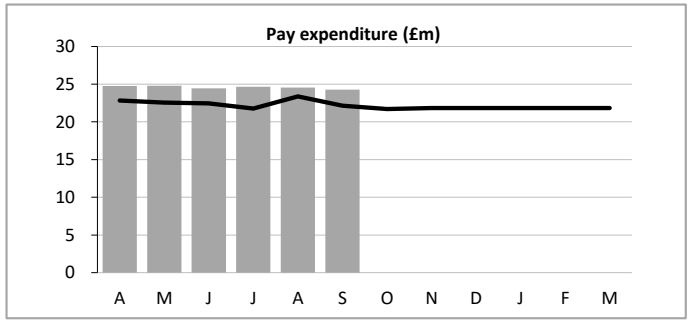
East and North Hertfordshire NHS Trust

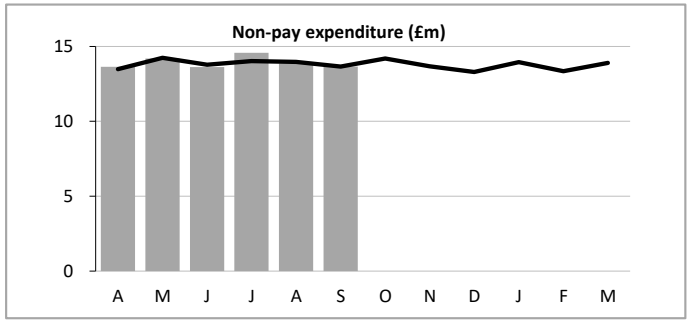
Domain	Metric	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	4	4	4	4	4	4	4	4	4	3	4	4		1	4	
	Liquid Ratio (Days)	4	4	4	4	4	4	4	4	4	4	4	4		1	4	
	I&E Margin	4	4	4	4	4	4	4	4	4	4	4	4		1	4	
	Distance from Plan	3	4	4	4	4	4	1	1	1	1	1	1		1	1	
	Agency Spend vs. Ceiling	1	1	1	1	1	1	1	1	1	1	1	1		1	1	
	Overall Finance Metric	3	3	3	3	3	3	3	3	3	3	3	3		1	3	











Sustainable Services

SLA Contracts - Income Performance

East and North Hertfordshire NHS Trust

		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Point of Delivery	A&E Attendances	2,091	2,316	225	12,754	13,857	1,103
	Daycases	2,719	2,752	32	16,127	17,121	994
	Inpatient Elective	2,096	1,614	-482	12,425	11,277	-1,149
	Inpatient Non Elective	8,180	8,156	-24	49,929	56,157	6,228
	Maternity	2,250	2,208	-42	13,636	13,574	-62
	Other	3,904	3,354	-550	23,060	20,018	-3,042
	Outpatient First	2,037	2,087	50	11,903	12,394	491
	Outpatient Follow Ups	2,262	2,018	-244	13,229	12,671	-559
	Outpatient Procedures	1,182	1,020	-162	6,908	6,490	-418
	Other SLAs	57	57	-0	344	344	0
	Block	842	836	-7	5,049	5,009	-40
	Drugs & Devices	3,516	3,640	123	21,098	21,153	55
	Chemotherapy Delivery	549	448	-101	3,292	3,024	-268
	Radiotherapy	1,113	1,143	30	6,681	6,962	282
	Renal Dialysis	1,088	1,074	-14	6,832	6,457	-375
	Total	33,886	32,723	-1,163	203,268	206,508	3,240

		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Commissioner	East & North Herts CCG	19,727	19,921	194	118,586	126,258	7,672
	Specialist Commissioning	7,711	7,524	-188	46,479	46,479	0
	Bedfordshire CCG	2,292	2,186	-106	13,789	14,417	628
	Herts Valleys CCG	1,351	1,378	27	8,129	7,698	-431
	Cancer Drugs Fund	444	488	45	2,662	2,466	-195
	Luton CCG	298	277	-21	1,791	1,830	39
	PH - Screening	293	267	-26	1,743	1,967	224
	Other	1,770	682	-1,088	10,089	5,393	-4,696
By Division	Cancer Services	6,312	6,359	47	37,751	37,967	216
	Medicine	10,728	10,707	-20	65,105	69,603	4,498
	Women & Children	4,655	4,454	-201	28,063	27,632	-431
	Clinical Services	2,150	2,043	-107	12,875	12,659	-216
	Surgery	9,987	9,600	-387	59,592	61,311	1,719
	Other	54	-441	-495	-118	-2,664	-2,546

Sustainable Services

Activity and Productivity

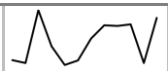
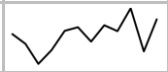
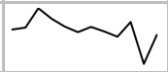
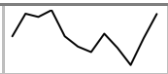
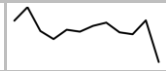
East and North Hertfordshire NHS Trust

Domain	Metric	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	13,296	12,622	12,516	12,876	12,086	13,475	12,680	13,521	12,942	13,968	12,845	13,236		74,534	79,192	4,658
	Chemotherapy Atts	2,349	2,335	2,083	2,296	2,001	1,983	2,223	2,239	1,948	2,266	1,983	1,832		13,504	12,491	-1,013
	Critical Care (Adult) - OBD's	839	569	566	729	464	577	636	628	580	671	535	719		3,331	3,769	438
	Critical Care (Paeds) - OBD's	589	404	486	398	379	442	421	628	427	516	465	549		3,313	3,006	-307
	Daycases	3,581	3,415	2,896	3,638	3,102	3,269	3,410	3,683	3,708	3,879	3,482	3,615		19,695	21,777	2,082
	Elective Inpatients	684	630	473	594	556	621	517	577	546	597	563	519		3,930	3,319	-611
	Emergency Inpatients	4,229	4,169	4,130	4,330	3,843	4,155	3,893	4,462	4,239	4,251	4,112	4,272		22,897	25,229	2,332
	Home Dialysis	182	175	186	195	163	178	176	173	161	158	163	147		971	978	7
	Hospital Dialysis	6,319	6,147	6,481	6,171	5,751	6,156	5,983	6,159	5,747	5,068	5,841	4,659		37,137	33,457	-3,680
	Maternity Births	478	464	447	441	381	445	422	461	427	453	449	451		2,766	2,663	-103
	Maternity Bookings	533	532	432	541	467	469	474	551	501	507	500	473		3,103	3,006	-97
	Outpatient First	10,324	9,662	7,733	9,289	8,293	9,261	8,456	9,132	8,996	9,845	8,220	9,208		49,319	53,857	4,538
	Outpatient Follow Up	20,360	19,161	14,070	19,489	17,002	17,277	17,151	17,763	16,960	19,196	15,884	16,646		109,312	103,600	-5,712
	Outpatient procedures	6,645	7,156	6,297	8,397	7,539	7,207	7,187	6,920	7,188	7,719	6,845	5,905		39,394	41,764	2,370
	Radiotherapy Fractions	5,125	5,273	4,381	5,286	4,773	5,048	5,023	5,023	4,338	4,884	4,775	4,423		28,595	28,466	-129

Sustainable Services

Activity and Productivity

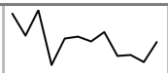
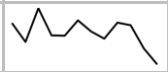
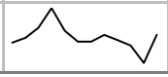
East and North Hertfordshire NHS Trust

Domain	Metric	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	185	184	211	192	183	185	196	203	203	203	184	207		188	199	12
	Emergency Spells per Day	125	128	123	129	127	125	126	140	137	133	129	139		125	138	13
	ED Attendances per Day	429	421	404	415	432	435	423	436	431	451	414	441		407	433	25
	Outpatient Atts per Working Day	1,623	1,635	1,756	1,690	1,642	1,607	1,640	1,610	1,578	1,671	1,407	1,588		1,572	1,581	9
	Elective Bed Days Used	1,692	1,544	1,124	1,311	1,255	1,445	1,348	1,466	1,247	1,500	1,459	1,240		8,806	8,260	-546
	Emergency Bed Days Used	16,732	14,979	15,192	16,528	15,146	16,380	15,538	16,653	15,153	16,643	15,030	15,312		95,337	94,329	-1,008
Efficiency	Admission Rate from A&E	24%	25%	25%	25%	24%	23%	23%	24%	23%	22%	24%	25%		23.3%	23.3%	0.0%
	Emergency - Length of Stay	4.0	3.6	3.7	3.8	3.9	3.9	4.0	3.7	3.6	3.9	3.7	3.6		4.1	3.7	-0.4
	Emergency - Casemix Value	2,033	2,018	2,103	2,170	2,194	2,119	2,353	2,221	2,349	2,459	2,243	2,247		2,219	2,312	93
	Elective - Length of Stay	2.5	2.5	2.4	2.2	2.3	2.3	2.6	2.5	2.3	2.5	2.6	2.4		2.3	2.5	0.2
	Elective - Casemix Value	1,161	1,197	1,134	1,113	1,137	1,132	1,148	1,156	1,130	1,125	1,162	1,052		1,202	1,129	-73
	Elective Surgical DC Rate %	84.0%	84.4%	86.0%	86.0%	84.8%	84.0%	86.8%	86.5%	87.2%	86.7%	86.1%	87.4%		85%	87%	1.8%
	Outpatient DNA Rate % - 1st	12.0%	11.9%	12.8%	12.4%	12.5%	11.6%	11.9%	12.0%	11.7%	11.6%	12.0%	11.3%		12.6%	11.9%	-0.7%
	Outpatient DNA Rate % - FUP	7.5%	7.7%	8.2%	7.6%	7.1%	7.1%	7.6%	7.9%	7.9%	7.3%	7.3%	7.2%		8.5%	7.7%	-0.8%
	Outpatient Cancel Rate % - Patient	9.4%	9.3%	10.3%	9.5%	9.6%	9.5%	10.0%	10.1%	10.6%	10.3%	10.7%	10.4%		9.3%	10.3%	1.0%

Sustainable Services

Activity and Productivity

East and North Hertfordshire NHS Trust

Domain	Metric	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	6.6%	6.4%	6.7%	6.1%	6.3%	6.4%	6.3%	6.4%	6.2%	6.2%	6.1%	6.3%		6.3%	6.3%	-0.1%
	Outpatients - 1st to FUP Ratio	2.0	2.0	1.8	2.1	2.1	1.9	2.0	1.9	1.9	1.9	1.9	1.8		2.2	1.9	-0.3
	Theatres - Ave Cases Per Hour	2.8	2.6	2.9	2.7	2.7	2.8	2.7	2.6	2.8	2.8	2.6	2.4		2.9	2.6	-0.2
	Theatres - Utilisation of Sessions	82%	81%	78%	76%	78%	80%	78%	80%	81%	82%	76%	75%		85%	79%	-6%
	Theatres - Ave Late Start (mins)	28	28	26	25	23	25	25	23	23	25	26	24		27	24	-2.4
	Theatres - Ave Early Finishes (mins)	36	38	41	47	40	37	37	39	37	36	30	39		39	36	-3.1

Sustainable Services

Cost Improvement Plan (CIP) Delivery

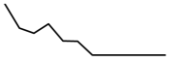
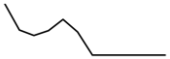
East and North Hertfordshire NHS Trust

Domain	Metric	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend	Annual Plan	Plan YTD	Actual YTD	Variance YTD
CIP Delivery by Workstream	Theatre Efficiency	5	1	0	0	63	39	0	0	0	0	0	0		106	101	108	7
	Outpatients	4	4	5	7	9	13	0	0	0	0	0	0		613	285	41	-244
	Procurement	442	231	166	226	203	216	0	0	0	0	0	0		3,145	1,404	1,484	80
	Divisional Non Pay schemes	102	106	114	81	162	156	0	0	0	0	0	0		1,642	562	720	158
	DQ, Coding & Income	0	0	42	41	366	176	0	0	0	0	0	0		1,691	408	624	216
	Corporate	144	119	24	140	50	52	0	0	0	0	0	0		1,117	568	530	-38
	Demand Management	43	64	75	70	94	67	0	0	0	0	0	0		1,480	467	413	-54
	Workforce Temporary Staff reduction	83	44	63	83	40	34	0	0	0	0	0	0		1,012	354	347	-7
	Divisional Pay schemes	254	257	238	274	177	197	0	0	0	0	0	0		1,998	1,145	1,397	252
	Workforce transformation schemes	-10	-16	58	-43	17	44	0	0	0	0	0	0		926	-46	50	96
	Divisional Income capture & coding	28	23	27	405	141	120	0	0	0	0	0	0		1,691	642	745	102
	Patient Flow	0	0	0	0	21	1	0	0	0	0	0	0		463	103	21	-82
	Divisional Local Income schemes	24	51	40	18	348	46	0	0	0	0	0	0		1,409	519	528	9
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,292	0	0	0
	Total CIP Delivery	**1,120**	**884**	**852**	**1,301**	**1,690**	**1,161**	**0**	**0**	**0**	**0**	**0**	**0**		**15,001**	**6,512**	**7,009**	**496**

Sustainable Services

Cost Improvement Plan (CIP) Delivery

East and North Hertfordshire NHS Trust

Domain	Metric	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend	Annual Plan	Plan YTD	Actual YTD	Variance YTD
CIP by Nature	Recurrent	467	540	571	905	1,508	983	0	0	0	0	0	0		14,710	4,712	4,975	263
	Non-Recurrent	652	344	280	397	182	179	0	0	0	0	0	0		2,581	1,801	2,034	233
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,291	0	0	0
	Total CIP Delivery	**1,120**	**885**	**852**	**1,301**	**1,690**	**1,161**	**0**	**0**	**0**	**0**	**0**	**0**		**15,000**	**6,512**	**7,009**	**496**
CIP Delivery by Division	Cancer Services	164	193	177	163	173	206	0	0	0	0	0	0		1,688	862	1,076	215
	Clinical Support	93	95	114	120	459	142	0	0	0	0	0	0		3,304	1,085	1,024	-62
	Corporate	582	286	222	278	406	264	0	0	0	0	0	0		3,897	1,810	2,038	228
	Medicine	79	101	115	441	258	266	0	0	0	0	0	0		4,048	1,182	1,260	78
	Surgery	127	141	110	166	253	183	0	0	0	0	0	0		3,164	1,081	980	-101
	Women's & Children's	74	69	113	133	141	100	0	0	0	0	0	0		1,190	492	630	138
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,290	0	0	0
	Total CIP Delivery	**1,120**	**884**	**852**	**1,301**	**1,690**	**1,161**	**0**	**0**	**0**	**0**	**0**	**0**		**15,001**	**6,512**	**7,009**	**496**

Sustainable Services

East and North Hertfordshire NHS Trust

Cost Improvement Plan (CIP) Delivery

Domain	Metric	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend	Annual Plan	Plan YTD	Actual YTD	Variance YTD
CIP Delivery by Type	Income (other operating income)	33	55	44	396	118	-21	0	0	0	0	0	0		1,893	673	626	-47
	Income (patient care activities)	23	23	70	72	740	367	0	0	0	0	0	0		3,261	930	1,294	364
	Non-Pay	732	456	400	522	517	494	0	0	0	0	0	0		7,409	2,935	3,122	187
	Pay (skillmix)	155	148	181	170	258	274	0	0	0	0	0	0		3,283	1,186	1,187	1
	Pay (WTE reductions)	177	201	157	141	55	47	0	0	0	0	0	0		1,445	789	779	-10
	Over/Unidentified	0	0	0	0	0	0	0	0	0	0	0	0		-2,291	0	0	0
	Total CIP Delivery	**1,120**	**884**	**852**	**1,301**	**1,690**	**1,161**	0	0	0	0	0	0		**15,000**	**6,512**	**7,009**	496

Sustainable Services

Productivity and Efficiency of Services - 2018-19 YTD vs. 2019-20 YTD

NHS East and North Hertfordshire NHS Trust

Activity Measures	2018-19 YTD	2019-20 YTD	Change
Emergency Department Attendances	76,121	79,192	3,071
Emergency Department Ave Daily Atts	416	433	17
Admission Rate from ED %	22.6%	23.3%	1%
Non Elective Inpatient Spells	23,270	25,229	1,959
Ave Daily Non Elective Spells	127	138	11
Daycase Spells	19,008	21,777	2,769
Elective Inpatient Spells	3,779	3,319	-460
Ave Daily Planned Spells	125	137	13
Day Case Rate	83%	87%	3%
Adult & Paeds Critical Care Bed Days	6,508	6,775	267
Outpatient First Attendances	52,647	53,857	1,210
Outpatient Follow Up Attendances	105,366	103,600	-1,766
Outpatient First to Follow Up Ratio	2.0	1.9	-0.1
Outpatient Procedures	38,165	41,764	3,599
Ave Daily Outpatient Attendances	1,072	1,089	17

Workforce Measures	2018-19 YTD	2019-20 YTD	Change
Average Monthly WTE's Utilised	5,618	5,857	240
Average YTD Pay Cost per WTE	24,415	25,187	3.2%
Staff Turnover	13.8%	12.8%	-1.0%
Vacancy WTE's	901	863	-38
Vacancy Rate	15.3%	13.9%	-1.4%
Sickness Days Lost	37,200	38,869	1,669
Sickness Rate	4.0%	3.9%	-0.1%
Agency Spend- £m's	6.2	6.3	0.1
Temp Spend as % of Pay Costs	4.5%	4.3%	-0.3%
Ave Monthly Consultant WTE's Worked	306.3	327.1	20.8
Consultant : Junior Training Doctor Ratio	1 : 1.7	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,399.1	2,461.5	62.3
Qual : Unqualified Staff Ratio	69 : 26	67 : 26	-0.1
Ave Monthly A&C and Senior Managers WTE's	1,229	1,299	69
A&C and Senior Managers % of Total WTE's	21.9%	22.2%	0.3%

Sustainable Services

Productivity and Efficiency of Services - 2018-19 YTD vs. 2019-20 YTD

NHS East and North Hertfordshire NHS Trust

Capacity Measures	2018-19 YTD	2019-20 YTD	Change
Non Elective LoS	4.1	3.7	-0.4
Elective LoS	2.3	2.5	0.2
Occupied Bed Days	104,143	102,589	-1,554
Adult Critical Care Bed Days	3,310	3,769	459
Paediatric Critical Care Bed Days	3,198	3,006	-192
Outpatient DNA Rate	10%	8%	-1.5%
Outpatient Utilisation Rate	28%	28%	-0.4%
Total Cancellations	59,342	65,410	6,068
Theatres - Ave Cases per Hour	2.8	2.6	-0.2
Theatres - Ave Session Utilisation	80%	79%	-1.5%
Theatres - Ave Late Start (mins)	30	24	-6
Theatres - Ave Early Finishes (mins)	40.4	36.2	-4
Radiology Examinations	202,592	207,313	4,721
Drug Expenditure (excl HCD & ENH Pharma) - £000s	5,284	4,512	-772
High Cost Drug Expenditure - £000s	19,732	20,744	1,012

Finance & Quality Measures	2018-19 YTD	2019-20 YTD	Change
Profitability - £000s	-12,154	-3,381	8,773.4
Monthly SLA Income £000s	32,162	34,532	2,370
Monthly Clinical Income per Consultant WTE	£105,008	£105,560	£552
High Cost Drug Spend per Consultant WTE	£64,425	£63,411	-£1,013
Average Income per Elective Spell	£1,175	£1,129	-£46
Average Income per Non Elective Spell	£2,090	£2,312	£221
Average Income per ED attendance	£171	£175	£4
Average Income per Outpatient Attendance	£132	£138	£6
Ave NEL Coding Depth per Spell	n/a	n/a	n/a
Procedures Not Carried Out	1,034	1,187	153
Best Practice HRGs (% of all Spells)	9.8%	2.0%	-7.8%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Mar-19	828	936	108
Non-elective re-admissions within 30 days % Rolling 12-months to Mar-19	8.2%	8.7%	0.5%
SLA Contract Fines - £000's	24	0	-24

Division	Not started	In progress	Passed	Total	%
ALL	3		2	5	40%
CANCER	69	10	33	112	29%
CAPITAL	4		1	5	20%
CSS	44	7	43	94	46%
MEDICINE	226	28	59	313	19%
SURGICAL	166	10	81	257	32%
W&C	73	11	80	164	49%
DATA QUALITY/CODING	5	1	2	8	25%
FACILITIES	3	2	1	6	17%
FINANCE	153	14	161	328	49%
FINANCE - INFORMATION	4	1	3	8	38%
FINANCE - IT		2	3	5	60%
NURSING PRACTICE	9	1	3	13	23%
PERF MGT			3	3	100%
PMO	8	3	58	69	84%
STRATEGY	3			3	0%
TRUST MGT	3			3	0%
WORKFORCE	12		4	16	25%
#NA			5	5	100%
Grand Total	**785**	**90**	**542**	**1,417**	**38%**

East and North Hertfordshire NHS Trust

Agenda Item: 9.2

TRUST BOARD - PUBLIC SESSION – 6 NOVEMBER 2019

FINANCE AND PERFORMANCE COMMITTEE – 25 SEPTEMBER 2019
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Finance and Performance Committee (FPC) meeting held on 25 September 2019. The report includes details of any decisions made by the FPC under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of FPC	**Presented by:** Chair of FPC	**Author:** Trust Secretary/ Trust Committee Secretary

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

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

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

FINANCE AND PERFORMANCE COMMITTEE – 25 SEPTEMBER 2019

EXECUTIVE SUMMARY REPORT TO TRUST BOARD – 6 NOVEMBER 2019

The following Non-executive Directors were present:
Karen McConnell (FPC Chair), Ellen Schroder (Trust Chair), Jonathan Silver (Non-Executive Director), Bob Niven (Non-executive Director)

The following core attendees were present:
Nick Carver (Chief Executive), Martin Armstrong (Director of Finance), Julie Smith (Chief Operating Officer), Duncan Forbes (Chief People Officer), Michael Chilvers (Medical Director), Rachael Corser (Director of Nursing).

MATTERS CONSIDERED BY THE COMMITTEE:

THEATRE AND OUTPATIENTES UPDATES
The FPC received an update on the progress of the theatre transformation programme following discussion at previous FPC meetings. It was reported that the work was taking place on a speciality by speciality basis. Initial work had taken place in Ophthalmology and it was felt good progress was being made. The Committee requested that details of the planned savings be presented at the next meeting.

The Committee also received an update on the work of the Outpatients programme. The Division reported on ongoing work to improve communication with patients and reduce cancellations and DNAs. Again, the Committee requested that savings plans be included in the next report to be presented to the FPC.

IT DELIVERY
The Chief Information Officer provided an update on the IT programme. The Chief Information Officer reported on projects, including details of equipment upgrades and projects in the pipeline. The Committee was pleased to note that the use of large screen monitors to support observations had been well received across the wards.

DIGITAL STRATEGY
The Committee was presented with the draft digital strategy. The Chief Information Officer reported that the document set out the proposed overall IT strategy for the next 5 years in support of the Trust's 2019 – 2024 Clinical Strategy. He reported that the digital foundations were now in place and highlighted the challenges and timeline for delivery of various aspects of the strategy. The Committee noted that there had been good engagement with clinical staff. The Committee supported the draft strategy.

INTEGRATED PERFORMANCE REPORT
The Safe & Caring and Effective sections of the Integrated Performance Report had been discussed in detail at the Quality and Safety Committee meeting on 24 September 2019.

Responsive Services:
Key points regarding responsive services included:

- 4-hour ED Target – Performance had improved to 86.11%, an improvement of 4.5% on previous month.
- 5 national cancer targets were delivered.
- 62 Day Standard – Improved Performance was noted compared to the previous month.
- Diagnostics – The August position was compliant at 0.63% against the national target of 1%.

- Stroke - Performance for August is 64.50%. This represents an improvement in month from the previous position.
- RTT – Performance had deteriorated slightly to 85.18%.

The Chief Operating Officer also provided an update to the FPC on winter planning, advising that work was taking place to assess the additional capacity that would be needed and how this could be addressed.

Well-led Services:
The key points reported regarding well-led services included:

- Staff turnover had reduced, especially in nursing and midwifery staff.
- The sickness absence rate remained on target.
- The staff flu campaign and staff survey were both due to be launched at the end of September
- The Committee discussed the challenges with the pay-bill and were advised that work was taking place to assess why temporary staffing demand was not reducing.

The Sustainable services section of the IPR was covered through other reports on the agenda.

BOARD ASSURANCE FRAMEWORK
The FPC received an update on the BAF risks and actions in place to mitigate against them. The key updates were:

- The risk relating to MVCC had been increased following the outcome of the strategic review and the potential delay to identifying the new tertiary provider.
- The EU exit risk had been reviewed and increased to 16; weekly planning meetings were in place to support our business continuity.
- The IM&T risk and score had been updated following comments at the last FPC.

WORKFORCE RISK UPDATE
The FPC received an update on the workforce and organisation development risks currently identified on the Trust's risk register, including controls in place, and actions for mitigation. The Committee noted the update.

WRES REPORT
The FPC received a report on the Workforce Race Equality Standard (WRES) data and analysis for approval. The report provided assurance to NHS England, the commissioners and the Trust's Black and Minority Ethnic (BAME) staff, as well as the wider workforce, on the effective implementation of the NHS Workforce Race Equality Standard. The FPC asked for an update on benchmarking for a future meeting and to receive regular updates on the metrics. The Committee approved the papers subject to those comments.

INDEPENDENT CONTRACTORS
An update was provided to the Committee on high value agency and independent contractors. It was reported that the Trust was continuing to monitor the use of contract workers as part of the work to address the pay-bill challenges.

EU EXIT PREPAREDNESS
The FPC received an update regarding the Trust's preparedness for a possible 'no-deal' EU exit. It was reported that critical areas have been identified and plans are in place to ensure business continuity. The BAF risk around EU exit preparedness had also been updated.

BED AND MATRESS REPLACEMENT
The Committee was informed of the outcome of the recently undertaken bed replacement tender. Following consideration of the proposal, The Committee approved the awarding of a 7 year contract for replacing beds as per the recommendation set out within the report.

M5 FINANCE REPORT
The Director of Finance presented the Committee with the Month 5 Finance Report. He reported on financial risks and ongoing actions to improve and mitigate against them. It was also noted that a Task and Finish Group had been set up to work on compliance on the completion of discharge summaries.

CIP UPDATE
The Committee noted the latest CIP report. Actions are ongoing to ensure CIP delivery.

FORECAST OUTURN REVIEW
The FPC received an update on the 2019/20 forecast outturn review. The analysis indicated a potential gap. It was considered that the gap could be closed in the remainder of the year.

LONG TERM FINANCIAL PLAN
The FPC was presented with the initial provisional submission of the long term financial plan. Final submission was required in November and the next version would be discussed at the October FPC meeting.

MVCC TRANSFER UPDATE
The Finance and Performance Committee was provided with updates on the work taking place regarding the specialist commissioner's strategic review regarding Mount Vernon Cancer Centre. A Task and Finish Group was set up to support implementation of the recommendations relating to transferring to a tertiary provider and plans were in place to ensure the FPC was kept updated regarding progress.

STRATEGIC PROJECT REPORT
The Committee received an update on the strategic projects that were currently ongoing. The Committee noted the report.

ANNUAL REVIEW
The FPC was presented with the annual review of the effectiveness of the committee and its terms of reference. The FPC approved the report and proposed changes to the terms of reference, including changing the name of the Committee to the Finance, Performance and Workforce Committee.

The report and terms of reference are attached as item 10.1.

Karen McConnell
Finance and Performance Committee Chair

September 2019

East and North Hertfordshire NHS Trust

Agenda Item: 9.2

TRUST BOARD - PUBLIC SESSION – 6 NOVEMBER 2019

FINANCE AND PERFORMANCE COMMITTEE – 30 OCTOBER 2019
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Finance and Performance Committee (FPC) meeting held on 30 October 2019. The report includes details of any decisions made by the FPC under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of FPC	**Presented by:** Chair of FPC	**Author:** Trust Secretary/ Board Committee Secretary

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

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

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

FINANCE AND PERFORMANCE COMMITTEE – 30 OCTOBER 2019

EXECUTIVE SUMMARY REPORT TO TRUST BOARD – 6 NOVEMBER 2019

The following Non-executive Directors were present:
Karen McConnell (FPC Chair), Ellen Schroder (Trust Chair), Jonathan Silver (Non-Executive Director), Bob Niven (Non-executive Director)

The following core attendees were present:
Nick Carver (Chief Executive), Martin Armstrong (Director of Finance), Julie Smith (Chief Operating Officer), Tom Pounds (Deputy Director of Workforce and OD), Michael Chilvers (Medical Director), Susan Wilkinson (Deputy Director of Nursing).

MATTERS CONSIDERED BY THE COMMITTEE:

THEATRE AND OUTPATIENTS TRANSFORMATION PROGRAMME UPDATES
The FPC received an update on the progress of the theatre transformation programme following discussion at previous FPC meetings. The Division provided a report on actions that are now in place to improve theatre utilisation. Performance in October to date was looking promising. It was agreed that there would be a further update in November. Savings of £392k to the end of the financial year had now been quantified. The Committee thanked the team for the update and for the improvements to date.

The FPC also received an update on the outpatients transformation programme. It was reported that work is ongoing in terms of implementing an IT solution to improve effectiveness of booking and cancellations. The Committee noted the update.

WINTER PLANNING
The FPC undertook a deep dive into winter planning. A comprehensive range of mechanisms to manage winter pressures were presented by the Chief Operating Officer (COO). The COO explained the plans to manage demand and capacity, the mechanisms for reviewing the effectiveness of those plans and responded to questions from the Committee. Work is ongoing to ensure Same Day Emergency Care (SDEC) is in place. An additional winter ward would be opened but much of the demand would be managed through reductions in length of stay. The FPC discussed the involvement of other local healthcare providers.

BOARD ASSURANCE FRAMEWORK AND RISK REPORT
The FPC received an update on the BAF risks and actions in place to mitigate against them. It was reported that the Audit Committee received a deep dive on risk 1 (regarding capacity and performance). The Committee discussed the risk regarding MVCC and requested an update report for the next meeting.

The Committee also received a report regarding risk register entries related to the FPC's remit. The Committee discussed the estates risks and noted a report regarding estates compliance would be provided for the next meeting.

INTEGRATED PERFORMANCE REPORT
The FPC was presented with the latest Integrated Performance Report. The safe, caring and effective elements were also discussed at the Quality and Safety Committee meeting on 29 October 2019.

Safe & Caring Services
The FPC received a brief update regarding the safe and caring services. It was reported that one Never Event had been declared in September and another in October.

Effective Services
The FPC received an update on effective services. It was reported that the mortality data provider would be changing. This could lead to some challenges with comparison of the data in the short term.

Responsive Services:
Key points regarding responsive services included:

- 4-hour ED target – Performance remains steady at 85% with 93.57% reported yesterday.

This increase in performance moved the Trust into the upper 3rd centile for ED 4 hour performance across the Midlands and East Provider Trust grouping.

- Cancer performance is 73.3% and is a focus for improvement
- Diagnostics – performance remained compliant.
- Stroke - Performance is 79.7%. This represents an improvement in month from the previous position.
- RTT – Performance remains at 85.17%.

Well-led Services:

The key points reported regarding well-led services included:

- There had been an improvement noted in terms of pay-bill management
- The sickness and absence rate had increased last month
- The number of flu vaccinations undertaken was higher than at the same point last year but work was continuing to ensure that front-line staff are vaccinated.

The Sustainable services section of the IPR was covered through other reports on the agenda.

PEOPLE STRATEGY UPDATE

The FPC was presented with an update on the development of a new People Strategy. The presentation set out the context, process and four key pillars identified for the strategy. It was reported that the current strategy was a five year plan which was due to come to an end in 2019. The FPC was impressed by the findings of the staff engagement exercises already undertaken. The FPC discussed some of the key findings, supported the direction of travel, and noted the update.

RESOURCING UPDATE

The FPC was provided with an update on nursing recruitment and resourcing. It was reported that the retention rate has improved and the Trust was intending to recruit a small additional number of international nurses. The Committee noted the update.

STATUTORY AND MANDATORY TRAINNING UPDATE

The FPC Received an update on statutory and mandatory training. It was reported that overall training compliance of the Trust was 86.86%. Plans are being developed to improve all statutory and mandatory training by improving access to e-learning and materials available to staff. The Committee commented on migration to e- learning and its accessibility to staff.

M6 FINANCE REPORT

The Committee was presented with the Month 6 Finance Report. Month 6 year to date position was a £3.4m deficit against a planned deficit of £4.8m. There had been some improvement in the pay-bill but inpatient elective activity had reduced in the month.

NON ELECTIVE OVERPERFORMACE

The FPC was provided with an update on non-elective over performance. The update identified the source of the increased activity the Trust had been experiencing.

OUTTURN FORECAST

The FPC received an update on the 2019/20 forecast outturn review. The Committee agreed it was important for the financial plan to be achieved. Plans were in place to mitigate the risks.

CIP UPDATE

The FPC noted the update regarding CIP performance.

PROCUREMENT UPDATE

The Committee was provided with an update on procurement. It was reported that there were proposals to change the structure of the procurement function. The Committee requested that an update should be provided at a future FPC meeting.

CAPITAL PLANNING UPDATE
The Committee received an update on the Trust's capital position as at October 2019. The Committee discussed the need to develop an understanding of all capital requirements and be ready to submit applications for capital spending should additional funds become available

EU EXIT PREPAREDNESS
The FPC received an update on work underway across the Trust and with strategic partners, in line with government guidance; to identify and mitigate risks and support business continuity in the event of a 'No Deal' EU Exit.

Karen McConnell
Finance and Performance Committee Chair

October 2019

East and North Hertfordshire NHS Trust

Agenda Item: 10.1

TRUST BOARD – PUBLIC SESSION – 6 NOVEMBER 2019
FINANCE AND PERFORMANCE COMMITTEE ANNUAL REVIEW 2018-19

Purpose of report and executive summary (250 words max):
The purpose of the report is to provide the findings of the Finance and Performance Committee annual review for 2018-19.

This review concludes that the Finance and Performance Committee met its duties and responsibilities in the period and the financial and operational improvements within the Trust in 2018/19 are evidence of this. However it is also recognised that there are plans to strengthen reporting of certain workforce items at the FPC (and also at the Quality and Safety Committee), to ensure these items receive sufficient focus at the Board sub-committee level.

To support the strengthening and effectiveness of the Committee the following recommendations are highlighted from the review:

- to encourage further streamlining of reporting through the IPR and to give consideration to removing the duplicated summary information,
- to continue to encourage succinct and focussed reports and discussions at meetings to ensure that there is sufficient time to cover the agenda items,
- that the arrangements regarding workforce issues that are due to be implemented from September 2019 continue to be monitored, allowing further review and adjustments to take place over the course of 2019/20 if required.

The Board is asked to approve the annual review and revised terms of reference.

Action required: For approval

Previously considered by:
FPC – 25.09.19

Director:	**Presented by:**	**Author:**
Director of Strategy	FPC Chair	Trust Secretary

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Not directly

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

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

Finance and Performance Committee
Annual Review 2018/19

Executive Summary

The Finance and Performance Committee (FPC) is a key assurance committee of the Trust Board. As set out in its current Terms of Reference, the purpose of the FPC 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 achievement of financial targets, business objectives and the financial stability of the Trust.

The Committee reviews and monitors financial plans and their link to operational performance, oversees financial risk management, provides scrutiny and approval of business cases and the capital programme and maintains oversight of the finance function, key financial policies and other financial issues that may arise. The Committee also monitors the development and implementation of the IM&T strategy and some workforce matters.

This annual review of the FPC considers how the Committee has met its duties under its Terms of Reference during 2018/19. A review of the Committee's minutes, its reports to the Board, a review of the Trust's Standing Orders and Scheme of Delegation and a self-assessment survey that was completed by FPC members and attendees were all used to inform this report.

This review concludes that the Finance and Performance Committee met its duties and responsibilities in the period and the financial and operational improvements within the Trust in 2018/19 are evidence of this. However it is also recognised that there are plans to strengthen reporting of certain workforce items at the FPC (and also at the Quality and Safety Committee), to ensure these items receive sufficient focus at the Board sub-committee level.

The Committee's Terms of Reference have been reviewed as part of this process and some updates are proposed. In particular, the sections regarding the Committee's purpose and duties have been revised based on the outcome of the discussion at the Board Development session in June, consultation with the Committee Chair and feedback received through the self-assessment survey that was completed by FPC members and attendees. Appendix 1 sets out the revised FPC Terms of Reference for consideration by the Committee.

To support the strengthening and effectiveness of the Committee the following recommendations are highlighted from the review:

- to encourage further streamlining of reporting through the IPR and to give consideration to removing the duplicated summary information,
- to continue to encourage succinct and focussed reports and discussions at meetings to ensure that there is sufficient time to cover the agenda items,
- that the arrangements regarding workforce issues that are due to be implemented from September 2019 continue to be monitored, allowing further review and adjustments to take place over the course of 2019/20 if required.

The Committee is asked to:

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

Summary of Key Findings

Meetings and Membership
The FPC met monthly during 2018/19, with the exceptions of May 2018 due to a major incident and August 2018 when no Board committees are routinely scheduled. All meetings were quorate under the current Terms of Reference.

Mr Nick Swift chaired the Finance and Performance Committee from the start of 2018/19 until he left the Trust in October 2018. Following this, Mr Jonathan Silver took on the role of chair on an interim basis. Mrs Karen McConnell joined the Trust in January 2019 and has chaired the FPC from March 2019 to present.

Changes to the executive director roles during 2018/19 are reflected in the Trust's annual report. Most significantly for the FPC, Julie Smith joined the Trust as Chief Operating Officer in June 2018. The Director of Strategy and Chief People Officer left the Trust in January and February 2019 respectively. Following a period of interim cover, both posts have now been filled substantively.

There was a slight change to the format of the meetings from the start of 2019, when the Trust's new Integrated Performance Report (IPR) began to be provided to the Committee. This report collates key performance metrics based on the five core CQC inspection domains (safe, caring, well-led, responsive and sustainability) into a single document, allowing for greater triangulation of data. Consideration of the report forms a key part of the meeting and has replaced some previous reports. It is hoped that there could be scope for further streamlining by including additional data (that is currently provided in separate reports) within the IPR. It is recommended that this is encouraged by the FPC and that consideration is also given to whether some of the duplicated summary information could be removed.

Review of the role of the FPC in terms of workforce issues
In early 2019 it was recognised that workforce matters had not received as much focus at sub-committee level as ideally they should have. Consequently a trial period was commenced in which all workforce reports were considered by the FPC from April 2019. The findings of this trial period were that several of the workforce elements were better suited to the Quality and Safety Committee and the volume of reports made the FPC meetings difficult to manage. Consideration was given to the next steps, including the possibility of forming a separate workforce committee. At the Board Development session in June 2019 it was agreed that the current meeting structure was preferable and whilst FPC would maintain a greater oversight of workforce issues than it had done previously, there were some matters that were more relevant to the role of the Quality and Safety Committee and so should be included on their work plan. Additionally the Quality and Safety Committee is implementing a 'deep dive' meeting every other month, and it was suggested that the workforce deep dives could also take place at those meetings. Consequently, the agendas are currently being reviewed and it is the intention to implement revised annual cycles reflecting these recommendations from the September 2019 meetings.

FPC Member Survey

As in previous years, the efficacy of the FPC has been assessed by sending a questionnaire to Committee members and others who regularly attend the meetings. A total of 6 responses were received. A summary of the views submitted under each question are provided below:

Do you think the agenda covers the right items?
Respondents recognised the work that was taking place to incorporate workforce matters within the agenda.

Do you feel that enough time is left for discussion? Are discussions summarised and is the conclusion clear?
Respondents mostly felt that the discussion was good, albeit pressured by time constraints on some occasions.

Do you feel able to challenge the Trust at the meetings?
The majority of respondents felt that there was sufficient challenge, though there was a suggestion that there was room for further improvement.

Do you feel that enough time and attention is given to the key areas of the Committee's remit (see terms of reference for further details)?
Responses to this question were mixed. Again, it was recognised that this was an area of work in-progress and finalising the plans for workforce items would improve this. It was also suggested that there has been a lack of focus on the STP to date.

How do you feel the Committee has performed against the key areas identified for improvement in last year's annual review (listed below)?

To continue to strive for greater focus and effective scrutiny of performance and data quality and IM&T [Note: data quality now considered at Audit Committee]
On the whole, it was felt that there was positive progress against this recommendation.

To encourage short reports that provide an overview of the agenda item to allow for greater discussion time
There were mixed responses to this question, though no respondents felt that this had been totally addressed.

To give greater focus to scrutiny and approval of business cases and oversight of the capital programme
Most respondents recognised that there had been some improvement and this remained an area of work in-progress.

How has the Committee added value to the Trust's operations over the last year?
Respondents cited the challenge and scrutiny provided by the FPC which had led to better financial performance and control as an example of the FPC adding value to the Trust's operations over the last year.

Do you think the FPC links well with the Board and other sub-committees? How do you think this could be improved?
The IPR was cited as an example of a useful tool for triangulation with the work of the other sub-committees. Several respondents also referred to the work taking place to review which elements of the workforce portfolio are considered by which sub-committee.

Regarding the review of the FPC and QSC agendas that is currently taking place, do you have any specific views on the FPC Deep Dives and split of workforce items?
Deep dives: The main suggestions were around balancing the time spent on these items with ensuring the right level of focus on specific deep dive areas and holding presenters to account for the actions agreed.
Workforce items: Suggestions included FPC maintaining oversight of workforce control issues and QSC having oversight of the quality aspects of workforce. There was also a suggestion that the possibility of instigating a separate workforce committee should not be discounted.

Any other comments regarding how the Committee's effectiveness could be improved?
The suggestions were primarily around ensuring appropriate time and energy is focussed on high priority areas in an efficient way.

The main suggestions for improvement from the survey were in relation to finalising the position in terms of the Committee's responsibility for workforce issues. It is recommended that the arrangements regarding workforce issues that are due to be implemented from September 2019 continue to be monitored allowing further review and adjustments to take place over the course of 2019/20 if required.

Key duties and responsibilities of the FPC:

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

Key Financial Areas

Finance Planning
The FPC monitored financial performance against the financial plan at each meeting. The Trust agreed its financial plan for 2018/19 with NHS Improvement based on a control total of a deficit of £0.28 million. The Trust reported a deficit, after technical adjustments, of £13.54 million. Whilst the Trust's reported financial performance for 2018/19 has improved compared with 2017/18, it was at variance to plan expectations. The key features affecting financial performance during 2018/19 included a high level of emergency activity, operational issues with laminar-flows in Theatres and a material over-spend on the Trust's pay-bill. Whilst significant cost efficiencies were delivered (£18 million across the year), this did fall short of the ambitious target of £24.2 million that the Trust had set for the year. Updates were provided to the FPC at each meeting and an outturn forecast in the lead up to the year-end position.

Financial Reporting
The FPC monitored monthly variances to forecast for income, pay, non-pay expenditure, monthly cash flow and capital positions. Financial risks were considered on a monthly basis, as well as the BAF risks relating to the Trust's financial position.

Financial Planning 2018/19 and 2019/20
The FPC considered and approved the final budget of the financial plan 2019/20 and continued to monitor monthly updates on the previous year's plan.

Pay-bill Expenditure
The Committee continued to monitor workforce spend throughout the year. The agency spend finished the year under the ceiling level, however the FPC was concerned by a significant overspend against the pay-bill despite the improvements in managing agency spend. The FPC considered a deep-dive into the matter at the March 2019 meeting and has continued to receive regular reports on the issue into 2019/20 to date, with some improvements now starting to be seen.

CIP Performance
The FPC received a monthly update on CIP performance, starting with details of identification of plans, followed by information on implementation and delivery. Whilst the full £24.2 million target was not achieved, the Trust was able to deliver significant cost efficiencies totalling £18million, and a number of schemes that were not able to be achieved have carried over into 2019/20.

Further key financial areas of scrutiny included:

- The FPC received updates on the Accountability Review Meetings with the Divisions.
- The Committee was informed of progress and challenges relating to CQUIN delivery.
- Updates were provided regarding procurement services.

Performance

The FPC received a monthly performance update (either through the Performance Report or, latterly, through the Integrated Performance Report). These reports provided the FPC with the latest data and context regarding performance, allowing the Committee to challenge and seek assurance in areas of underperformance. Key headlines at year-end included:

- ED Performance
  The national target is for 95% of patients to be seen, treated and either admitted or discharged within four hours of arrival. The Trust achieved this for 85.85% of patients in 2018/19.

- RTT Performance
  The Trust returned to reporting RTT performance in October 2018 following a prolonged period of data validation and Patient Tracking List (PTL) development. The Trust reported an improving position against this standard at year end.

- Cancer Performance
  - Cancer two week referrals – the Trust continued to deliver two-week waits for GP referrals to first outpatient appointment and also for those with breast symptoms (the average year-end figures for 2018/19 are 94.8% and 92.6% respectively).
  - Cancer 62-day referral to treatment – average year-end figures for 2018/19 are 69.1% pre-breach/compliance sharing and post –breach sharing 73.1% against the national 85% standard. A revised recovery trajectory has been agreed with external stakeholders and shows that the Trust will deliver 85% in October 2019 with associated investment.
  - Cancer 31-day decision to treat to first definitive treatment – the Trust's achieved performance of 93.9% against a national standard of 96.0%.

Further key performance areas of scrutiny included:

- Deep dives on performance measures by Divisional teams.
- The impact of stabilisation work on operational performance and the gradual return to reporting of various metrics.
- Updates on winter initiatives in advance of and during the winter period.
- The FPC was kept informed of discussions with regulators regarding the challenges the Trust faced and any improvement plans and trajectories that were agreed.

Workforce

The FPC received regular updates through the workforce reports and Integrated Performance Report regarding workforce developments. Later in the year, these reports were expanded to cover a broader range of issues. The need to develop a people strategy was identified and this is being addressed during 2019/20.

Key workforce matters that were scrutinised by the FPC during the year included:

- Temporary staffing performance – the Trust closed the year 2% under the agency spend ceiling target, with agency spend making up 4.3% of the overall pay-bill.
- Vacancy and retention rates – the year-end vacancy rate was 7.2% (down from 8.4% the previous year). The turn-over rate ended at 13.3%, down from 13.5% at the same point the previous year.
- Staff sickness trends – the average rate of sickness absence was 4.3%.
- The uptake of the flu vaccination amongst staff – uptake was lower than targeted and discussions have already taken place to consider how to improve this for the 2019 campaign.
- Compliance with statutory and mandatory training and appraisal completion - there are plans to review the education and appraisal systems in 2019/20.
- The results of the staff survey – the latest results were disappointing and the FPC has been monitoring completion of the actions agreed since.

Other duties

Strategic Projects
The FPC received regular reports on key strategic projects and the work of the strategic programme board.

In addition, the FPC received the final draft of the Clinical Strategy for 2019-24 prior to its approval by the Trust Board in January 2019. A number of supporting strategies to enable the

implementation of the clinical strategy, including for finance and workforce, are currently under development.

BAF
The BAF continued to be monitored on a monthly basis to ensure it remains a 'live' and up to date register.

IM&T
The stabilisation work that began previously continued into 2018/19 and the Committee was kept informed of this work throughout the year.

Business cases
The FPC scrutinised and recommended the outline business case to procure a joint pathology service with the STP for Board approval and also approved the Electronic Prescribing and Medicines Administration outline business case at the meeting in January 2019.

Business planning 2019/20
The FPC reviewed the business planning reports for 2019/20, including the draft operating plan and draft plan on a page.

EU Exit
The FPC was kept informed of the Trust's plans regarding a possible 'no deal' EU exit.

Several matters were transferred to the remit of the Audit Committee during the course of 2018/19. These were: sustainability, data quality and clinical coding, cyber security, and the junior doctor quarterly update.

Reporting Arrangements

The Committee Chair presents a summary report to the Trust Board after each meeting. These reports have demonstrated that the Committee has monitored key areas of its duties and responsibilities, including risks, at each meeting.

The minutes demonstrated clear challenge and questioning to gain assurance. Progress throughout the year was well documented and discussed at Trust Board and FPC meetings.

The FPC Actions Log provides a clear audit trail of agreed actions together with closure of those actions. It was monitored by the Committee at each meeting. Any actions referred to FPC by other Board Committees were added to the FPC Actions Log and monitored through to completion by the Committee.

Conclusion

This review concludes that the Finance and Performance Committee met its duties and responsibilities in the period and the financial and operational improvements within the Trust in 2018/19 are evidence of this. However it is also recognised that there are plans to strengthen reporting of certain workforce items at the FPC (and also at the Quality and Safety Committee), to ensure these items receive sufficient focus at the Board sub-committee level.

The Committee's Terms of Reference have been reviewed as part of this process and some updates are proposed. In particular, the sections regarding the Committee's purpose and duties have been revised based on the outcome of the discussion at the Board Development session in June, consultation with the Committee Chair and feedback received through the self-assessment survey that was completed by FPC members and attendees. Appendix 1 sets out the revised FPC Terms of Reference for consideration by the Committee.

To support the strengthening and effectiveness of the Committee the following recommendations are highlighted from the review:

- to encourage further streamlining of reporting through the IPR and to give consideration to removing the duplicated summary information,
- to continue to encourage succinct and focussed reports and discussions at meetings to ensure that there is sufficient time to cover the agenda items,
- that the arrangements regarding workforce issues that are due to be implemented from September 2019 continue to be monitored, allowing further review and adjustments to take place over the course of 2019/20 if required.

The Committee is asked to:

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

Appendix 1

East and North Hertfordshire NHS Trust

FINANCE, PERFORMANCE AND WORKFORCE COMMITTEE

TERMS OF REFERENCE

1. Purpose

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

The Committee's work will include:

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

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

2. Status & Authority

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

3. Membership

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

Core Attendees:

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

Attendees:

Deputy Director of Workforce and OD
Chief Information Officer
PMO Director
Deputy Director of Finance

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

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

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

4. Quorum

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

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

5. Frequency of meetings

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

6. Duties

6.1 Financial Planning

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

To approve:

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

To approve and recommend to the Board:

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

To monitor and review:

- Enabling strategies (specifically the digital, estates, capital and people strategies) and their impact on the Medium Term Financial Strategy including the Long Term Financial Model;
- The capital programme and work of the Capital Review Group;
- The development of the annual Cost Improvement Programme and oversee development of the rolling programme that is to be incorporated into the Long Term Financial Model and monitor in year delivery;
- Value for money and efficiency issues as required to ensure problem areas are addressed and action taken as appropriate;
- Progress against the Sustainability Transformation Plan;
- The development of financial forecasts and measures taken to promote financial sustainability.

6.2 Investments

To recommend to the Board:

- A Treasury Management Policy including delegated arrangements and recommend its adoption by the Board. [Consider whether this should move to the remit of the Audit Committee]

To monitor and review:

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

6.3 Performance

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

To determine or approve:

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

To recommend to the Board:

- The application of contingency funding where appropriate;

To monitor and review:

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

6.4 Workforce

To monitor and review:

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

6.5 Other duties

To monitor and review:

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

6.6 Risk Reporting

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

7. Reporting arrangements

The Committee will identify and report the key issues requiring Board consideration to the Trust Board after each meeting.

It will make recommendations to the Board, Executive Team and Executive Directors for these groups/individuals to take appropriate action.

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

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

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

9. Support

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

Reviewed September 2019

East and North Hertfordshire NHS Trust

Agenda Item: 11 (a)

TRUST BOARD PART 1 – 6 NOVEMBER 2019

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 24 SEPTEMBER 2019

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of the 24 September 2019 to the Board.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Trust Secretary / Corporate Governance Officer

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

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

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

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 24 SEPTEMBER 2019

SUMMARY REPORT TO TRUST BOARD – 6 NOVEMBER 2019

The following Non-Executive Directors were present:

Ellen Schroder, David Buckle.

The following core attendees were present:

Nick Carver (Chief Executive), Jude Archer, Michael Chilvers, Rachael Corser, Julie Smith.

The following points are specifically highlighted to the Trust Board:

QTP Deep Dive: Safer Surgery/NatSSIP

The National Safety Standards for Invasive Procedures (NatSSIP) was published in September 2015 to help NHS organisations provide safer care and to reduce the number of patient safety incidents related to invasive procedures. Trusts clinical governance processes were to identify procedures across clinical settings that were applicable to their local conditions (LocSSIPs).

The Committee received a presentation on the development of the Trust's LocSSIP by a team of clinicians. They had developed and tested procedures based on the NatSSIP. The Team planned to launch the LocSSIP at an event on 1 October 2019.

The Committee commended the team on the excellent work they had done.

Learning from Deaths Report

The Medical Director presented the quarterly Learning from Deaths report which summarised the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work.

The Medical Director reported that:

- The development of the Mortality Review Tool was to commence following the purchase of DatixIQ;
- Medical Examiners had been appointed and implementation plans were in progress;
- Regular on-going mortality monitoring was continuing via the Mortality Surveillance Committee, Quality and Safety Committee, Board and joint meetings with ENHCCG.

Learning, Education and Talent Management Update

The Chief People Officer presented a report to update the Committee on the current progress of the Learning, Education and Development Review.

He reported that the project team had engaged stakeholders widely and had collected data from a number of sources. The report would be brought to the committee for consideration and approval in November.

Other outcomes:

Integrated Performance Report

The Integrated Performance Report - Month 5 was presented to the Committee.

Safe and caring

The Director of Nursing reported to the Committee.

In regard to patient experience, it had been a positive month but there had been a reduction in the number of outstanding complaint responses. Three infection incidents had been reported in August. All six sepsis targets were improving. There were better response times and screening in ED. Response on treating was almost 100% but it was recognised that there was further work to do on the other indicators. There had been a spike in the number of falls, particularly overnight.

Effective services

The Medical Director presented a report on effective services. He reported that there had been further improvements in mortality. A 7-days service steering group had been set up with very good clinical engagement.

Responsive Services

The Chief Operating Officer reported that it had been a relatively strong month with demonstrated improvement. ED saw improvement in the month. Cancer performance had improved. The 62-day performance for July 2019 was 79.3% which was below the revised trajectory of 80.3%. DM01 performance for August was 0.63% against the national standard of 1% and the July position of 0.56%.

RTT performance was at national level. Performance had worsened slightly in August and was below the August plan of 89.4%. Stroke performance for August was 64.50%. This represented an improvement from the previous month but the Trust was not at target level nationally. Planning for winter was continuing.

Well led

The CPO reported that the turnover rate was reducing. There were more nurses in posts. The Trust turnover rate was down by 1.7% in August 19 (12.5%) compared to August 18 (14.2%). Nursing and Midwifery staff level has reduced most significantly down to 11.6% from an average of 12.5%.

The plans for nursing recruitment for 19/20 were complete. Bank fill performance improved to 85% across all staff-groups. Agency utilisation had also reduced within Health Care Scientists (HCS) staff throughout 2019. Medical staffing remained problematic.

BAF and Corporate Risk Register Report

The Associate Director of Corporate Governance presented the latest version of the Board Assurance Framework 2019 -2020 to the Committee for consideration.

Risks that had been on the risk register for longer than two years were being examined to see whether they should be closed or whether further action was required. Emerging risks were also being examined.

Response to JW patient testimony

The Trust Board had heard difficult but sobering patient testimony from the Wilkinson family about the death of their sister at Lister Hospital. The Director of Nursing reported on progress. A response had been sent to the Wilkinson family, setting out the next steps and timelines. The outcome would be published in the Trust Board papers of the meeting to be held on 6 November 2019.

Infection Control

The Director of Nursing presented a report to inform the committee of infection prevention and control performance for the period 1 July to 31 August 2019.

Work was continuing to ensure that primary and secondary water control systems met required standards. Water oversight meetings were held to address gaps. Progress was encouraging but there were still risks.

The number of infection incidences was discussed. Cleanliness was still the focus.

Safer Staffing

The Director of Nursing presented the report to update the Quality and Safety committee on safe staffing levels for the month of August.

She reported that

- The Overall Fill Rate had decreased by 0.6% from 98.4% in July to 97.8% in August.
- Care Hours per Patient Day (CHPPD) increased from 7.5 in July to 7.9 in August as a result of reduced occupancy in August.
- Overall fill rate for temporary staffing decreased by 2.1% from 82.2% in July to 80.1% in August. Demand hours decreased by over 4,000 hours.

Clinical Harm Reviews Update

The Medical Director presented the clinical harm review update to inform the Committee of developments relating to the Harm Review Process.

The clinical harm review process provides assurance that there is Divisional and Executive oversight of potential or actual harm as an unintended consequence of delayed cancer treatment.

Clinical Effectiveness Report 2018-2019

The Medical Director presented the Clinical Effectiveness (CE) report which summarised the year-end (2018/19) Clinical effectiveness performance, developments and current risks.

Performance had declined and the Medical Director informed the Committee of the steps which were being taken to stabilise and improve the position. The Committee discussed the problems with non-compliance and how this could be addressed.

The Committee noted the contents of the report.

Patient Safety Incidents Report & Serious Incidents and Never Event Report

The Director of Nursing presented the Patient Safety Incidents report to inform the committee of patient safety incidents data, trends and themes.

The Director of Nursing also presented an update on serious incidents and never events. She reported that there had been a notable increase in reporting. There had been an ongoing improvement in safety data.

The Committee noted the contents of the report.

Nursing, Midwifery and Allied Professionals Strategy 2019-2024 Progress Review

The Director of Nursing presented a draft progress report on the Nursing, Midwifery and Allied Health Professionals Strategy 2019-24. The strategy was launched in May 2019. Wards were assessed against the six pillars. The Director of Nursing reported on progress in the six pillars. Work was progressing on developing standards.

The Committee noted the contents of the report.

Compliance Report

The Associate Director of Corporate Governance presented the CQC update. The purpose of this paper was to apprise the Committee of the latest release of the CQC Insight Dashboard, informal feedback from the CQC inspection and correspondence to CQC regarding the areas of concern raised and actions taken.

The Committee noted the report.

Q & S Review of CIP Programme

The Director of Nursing presented the review of the CIP programme to the Committee. The Committee discussed the presentation. The annual savings plan focused on influenceable spend; 65% of which related to pay, 35% to non-pay.

The following reports were noted by the committee

Maternity Dashboard

The Maternity dashboard was presented to inform the Committee about the Maternity Dashboard July 2019 exceptions, actions taken in response to the exceptions and safety concerns raised. The Committee noted the report.

QSC Subcommittee Escalation Reports

Patient and Carer Experience Committee Escalation Report

The report was submitted to inform the Committee of details of the meeting of Patient and Carer Experience Committee (PEC). The Committee noted the report.

Clinical Effectiveness Committee Escalation Report

The report was submitted to inform the QSC of matters escalated from the Clinical Effectiveness Committee. The Committee noted the report.

Patient Safety Committee Escalation Report

The report was submitted to inform the QSC of key matters considered by and escalated from the Patient Safety Committee following their meeting in August. The Committee noted the report.

_____

Ellen Schroder

Deputising for QSC Chair

September 2019

East and North Hertfordshire NHS Trust

Agenda Item: 11 (b)

TRUST BOARD - PUBLIC SESSION – 6 NOVEMBER 2019

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 29 OCTOBER 2019

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of the 29 October 2019 to the Board.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC / Deputy Chair of QSC	**Author:** Trust Secretary / Corporate Governance Officer

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

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

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

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 29 October 2019

SUMMARY REPORT TO TRUST BOARD –6 November 2019

The following Non-Executive Directors were present:

Val Moore, Ellen Schroder, David Buckle.

The following core attendees were present:

Nick Carver (Chief Executive), Jude Archer (Associate Director of Corporate Governance), Michael Chilvers (Medical Director), Julie Smith (Chief Operating Officer).

The following points are specifically highlighted to the Trust Board:

Surgery and Critical Care Deep Dive

The presentation was delivered to inform the Committee of the progress that had been made in the Surgery and Critical Care Division of the Trust over the last six months.

The Divisional Director reported that there had been a significant improvement from eight Never events in 2018 to one in 2019. Processes had been put in place to drive patient safety. An intensive drive was launched in theatres to train staff; introduce checklists; and improve culture.

NATSIP LOCCSIP was launched and being adapted to a LOCSSIP that could be used for all invasive procedures. The Committee was informed of the following developments:

- Discharge summaries were prioritised to ensure that follow-ups were done.
- An 8% decrease in falls when compared to the same period in 2018.
- Steps to ensure that medication was administered at the right time.
- A deteriorating patient learning collaborative was to be started in January to share the learning to improve the detection of and outcomes for deteriorating patients.

The Committee had some questions regarding deteriorating patients across the Trust. It was agreed that this should be covered through the deep dive scheduled on that work stream.

Harm Free Care Collaborative - Pressure Ulcers Deep Dive

A presentation on pressure ulcers (PU's) was delivered by the Associate Director of Nursing and the Lead Tissue Viability nurse (TVN). New NHSI recommendations on the reporting and counting of PU's had led to a sharp increase in the number of PU's reported. NHSI was to audit all the acute trusts to establish a national prevalence for Pressure Ulceration.

A skin inspection of 509 patients at Lister hospital and MVCC was conducted over two days for all patients except babies and those who declined. 51 patients were found to have a PU. This amounted to a prevalence of 10.01%. The TVN was confident that PU's were being identified by staff. Whilst there was limited benchmarking data available, it was believed that the Trust performed relatively well compared to local peers. A collaborative had been launched in September 2019 with 24 NHS England trusts to improve PU reporting and achieve a reduction in the numbers and severity of PU's. National Stop the Pressure day is 21 November 2019.

The Committee congratulated the team on their excellent work.

Pathway to Clinical Excellence Deep Dive

The Associate Director of Nursing delivered a presentation on the Pathway to Clinical Excellence. This is a nursing excellence framework which encourages personal and professional development whilst focussing on improving patient safety, patient experience and staff experience. The Trust had been selected as one of 14 Trusts, and one of three in the East of England, to participate in the first national cohort. The Pathway supports the culture of continuous quality improvement and ward performance from ward to board.

Benefits of the Pathway were improved productivity and reduced length of stay, improved work environment and job satisfaction and increased staff retention. Six Pathway standards are aligned to the Trust's Nursing, Midwifery and Allied Health Professionals Strategy. A communications launch, self-assessment and nurse survey were planned.

Other outcomes:

Perinatal Mortality Review Group Report

The report was submitted to assure the Committee of the contemporaneous and continuous monitoring of stillbirth and neonatal deaths. One of the ten safety standards set in the NHSR Maternity Incentive Scheme, was that the Trust was to use the Perinatal Mortality Review Tool (PMRT) to review and report perinatal deaths to the required standard. A report on the use of the said tool was required to be submitted to the Committee quarterly.

All stillbirths and neonatal deaths were reported via the Trusts DATIX system. Two Neonatal Deaths occurred at other Trusts following transfer of the baby from the Trust's Neonatal Unit.

Integrated Performance Report

The Integrated Performance Report - Month 6 was presented to the Committee.

Safe and caring

The Deputy Director of Nursing reported that improvement in complaints management had been noted from Jan - Aug 2019 with an overall 50% reduction in open cases. Responding to complaints within the agreed timeframe has increased to 75% year to date. Five pressure ulcers had been reported in September. 58 falls were recorded in September, 40 of which resulted in no physical harm to the patients involved. Hand hygiene compliance was at 91.4%.

Effective services

The Medical Director reported that mortality rates had improved over the last 5 years as measured by both of the major methods, HSMR and SHMI. He reported that HSMR had dropped significantly due to a change in data source from Dr Foster to CHKS because these two providers had different timeframes for re-basing their datasets. The latest SHMI for the rolling 12 months to May 2019 was 91.33 ('as expected' range).

Responsive Services

The Chief Operating Officer reported that the Trust delivered four compliant national cancer targets in August. The 62-day target was 73.3% which was below the revised trajectory of 82.1%. There were emerging risks regarding PET-CT delays at the Paul Strickland Scanning Centre and histopathology reporting delays due to a combination of reduction in WLIs as a result of the consultant tax issue and the retirement of a consultant. Both issues were being addressed. Stroke performance for September was 79.7%, demonstrating significant improvement from August.

Well led

There had been an increase in sickness absence in September. The staff flu vaccine campaign began on 30 September, aiming to vaccinate all staff with direct patient contact.

BAF and Corporate Risk Register Report

The Associate Director of Corporate Governance presented the latest version of the Board Assurance Framework 2019 -2020 to the Committee for consideration. She reported that the Trust had received three HSE improvement notices following the recent inspection. An action plan was being developed and updates would be presented through the Quality and Safety Committee to Board and monitored through the Health and Safety committee. The deadline to respond to the HSE was January 2020.

Junior Doctors Contract Quarterly Update

The latest quarterly report from the Guardian of Safe Working Hours was submitted to the Committee. The Guardian was required to provide a quarterly report to the Trust Board, summarising all exception reports, work schedule reviews and rota gaps, and providing assurance on compliance with safe working hours by both the employer and doctors in approved training programmes. The Committee noted the report.

Trainee Survey

A report on the results of the GMC 2019 National Training Survey was submitted to the Committee. The survey monitors the quality of medical education and training in the UK. The Committee noted the report and the results of the survey.

QSC Annual Review 2018-19

A report on the findings of the annual review of the Quality and Safety Committee was submitted. The review did not highlight any material issues. It concluded that the QSC had met its duties under its terms of reference in the period under review. It also recognised that there has been a recent change to the meeting structure and duties of the Committee in relation to workforce reporting and consideration of deep dives. It recommended that this should be monitored for the remainder of the year. The Committee suggested that a greater number of responses to the survey would strengthen the quality of the review in future.

The Committee's terms of reference had also been reviewed. The proposed amendments were primarily to clarify the duties and responsibilities of the QSC in relation to workforce matters. The Committee recommended the review and terms of reference to the Board for approval.

Emergency Planning Resilience and Response Report

The report was submitted to the Committee for approval of the EPRR Core Standards and Assurance Return which provides an overall compliance level against the standards of 'fully compliant'. The Committee approved the self-assessment and the overall self-assessment outcome of fully compliant.

September Trust Board Patient Testimony Update

A report was submitted to the Committee with an update on the actions the trust has taken in response to the learning from the serious incident investigation into the death of Janice Wilkinson following her death in February 2018 and the patient testimony provided by her family at the last Board meeting. A report would be compiled for submission to the Trust Board.

The following reports were noted by the committee

Safer Staffing Report

The report updated on safe staffing levels for the month of September and the impact this has on quality and safety, people productivity and financial sustainability. The Committee noted the report.

Infection Prevention and Control

The report was submitted to update the Committee on infection prevention and control objectives and outcomes in September 2019. The Committee noted the report.

Maternity Dashboard

The report was submitted to inform the Committee of the Maternity Dashboard exceptions for September 2019, the Maternity Services' analysis and actions in response to the exceptions and of safety concerns raised within maternity services. The Committee noted the report.

QSC Subcommittee Escalation Reports

Patient Safety Committee Escalation Report

The report was submitted to inform the Committee of key matters considered by and escalated from the Patient Safety Committee following their meeting in October 2019. The Committee noted the report.

_____

Val Moore

Deputising for QSC Chair

October 2019

East and North Hertfordshire NHS Trust

Agenda Item: 11.2

TRUST BOARD – PUBLIC SESSION – 6 NOVEMBER 2019
QUALITY AND SAFETY COMMITTEE ANNUAL REVIEW 2018-19

Purpose of report and executive summary (250 words max):
The purpose of the report is to provide the findings of the Quality and Safety Committee annual review for 2018-19.

The review has not highlighted any material issues. It concludes that the QSC has met its duties under its terms of reference. It also recognises that there has been a recent change to the meeting structure and duties of the Committee in relation to workforce reporting and consideration of deep dives, which it is recommended continues to be monitored for the remainder of the year.

The Committee's terms of reference have been reviewed and the proposed amendments are highlighted in Appendix 1. These are primarily to clarify the duties and responsibilities of the QSC in relation to workforce matters.

To support the strengthening and effectiveness of the Committee, the following actions are recommended for consideration:
• To continue to monitor the new meeting structure and workforce reporting over the course of the year, allowing for further review and adjustments to take place if required.
• To ensure the Committee is clear of the purpose of the reports it considers.
• To continue to encourage succinct and focussed reports and discussions at the meetings to ensure that there is sufficient time to cover the agenda items.

The Board is asked to approve the annual review and revised terms of reference.

Action required: For approval

Previously considered by:
QSC – 29.10.19

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

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Not directly

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

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

QUALITY AND SAFETY COMMITTEE
ANNUAL REVIEW 2018/19

Executive Summary

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

'…to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, research governance, information governance, health & safety, patient and public safety, organisational culture and OD and compliance with CQC regulation. The Committee will also be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the strategic objectives and quality transformation plan.'

This annual review considers how the QSC has met its duties under its terms of reference over the course of 2018/19. Consideration of the QSC meeting minutes, reports to the Board, Trust standing orders and scheme of delegation and the findings of a survey of QSC members have been used to inform the findings of this report.

The review has not highlighted any material issues. It concludes that the QSC has met its duties under its terms of reference. It also recognises that there has been a recent change to the meeting structure and duties of the Committee in relation to workforce reporting and consideration of deep dives, which it is recommended continues to be monitored for the remainder of the year.

The Committee's terms of reference have been reviewed and the proposed amendments are highlighted in Appendix 1. These are primarily to clarify the duties and responsibilities of the QSC in relation to workforce matters.

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

- To continue to monitor the new meeting structure and workforce reporting over the course of the year, allowing for further review and adjustments to take place if required.
- To ensure the Committee is clear of the purpose of the reports it considers.
- To continue to encourage succinct and focussed reports and discussions at the meetings to ensure that there is sufficient time to cover the agenda items.

The Committee is asked to:

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

Summary of Key Findings

Meetings and Membership

The QSC met eleven times during 2018/19. The meetings took place on a monthly basis, with the exception of August, when no Board committees are routinely scheduled.

The former Chair of the QSC, Mr John Gilham, left the Trust at the end of June 2018. Dr Peter Carter and Dr David Buckle joined the Trust as Non-executive Director and Associate Non-Executive Director respectively in September 2018. Both Dr Peter Carter and Dr David Buckle have been members of the Committee since that time, with Dr Peter Carter chairing the meetings from October 2018.

Changes to the executive director roles during 2018/19 are reflected in the Trust's annual report. Significant changes for the QSC included the appointment of the permanent Chief Operating Officer in June 2018, and the departure of the Director of Strategy and Chief People Officer in January and February 2019 respectively. Following a period of interim cover, both posts have now been filled substantively.

There was a slight change to the format of the meetings from the start of 2019, when the Trust's new Integrated Performance Report (IPR) began to be provided to the Committee. This report collates key performance metrics based on the five core CQC inspection domains (safe, caring, well-led, responsive and sustainability) into a single document, allowing for greater triangulation of data. Consideration of the report forms a key part of the meetings and, at the FPC, the IPR has superseded some previous reports. It is hoped that there could be scope for further streamlining reporting by including additional data (that is currently provided in separate, standalone reports) within the IPR.

QSC Sub-Committee Structure

From mid-2018, as part of the work of the quality transformation programme, the committees that report into the QSC were reviewed and their structures and terms of reference updated. An escalation report template was developed for the sub-committees to submit to the QSC after each meeting. The main QSC sub-committees now include the Clinical Effectiveness Committee, Patient and Carer Experience Committee, Patient Safety Committee, Trust Infection Prevention and Control Committee and Health and Safety Committee. This revised structure has improved the governance processes and improved the link in terms of escalation of issues from an operational level to the Board sub-committee.

Review of workforce reporting and QSC meeting format

The Committee's annual cycle was reviewed early in 2019 and has been monitored and tweaked on a rolling basis to help keep agendas manageable and to ensure that items of business are considered at the most appropriate time of the year.

In early 2019 it was recognised that workforce matters had not always received as much focus at sub-committee level as ideally they should have. Consequently, a three month trial period was commenced in which all workforce reports were considered by the FPC from April 2019. The findings of this trial period were that several of the workforce issues were better suited to consideration at the Quality and Safety Committee, and the volume of reports made the FPC meetings difficult to manage. Consideration was given to the next steps, including the possibility of forming a separate workforce committee. At the Board Development session in June 2019 it was agreed that the current meeting structure was preferable and whilst it was agreed that the FPC would maintain a greater oversight of workforce issues than it had done previously, there were some matters that were more relevant to the work of the Quality and Safety Committee and so should be included on their work plan.

Additionally, the Chair of the Quality and Safety Committee had asked that consideration was given to focussing the QSC meetings so that every other meeting could be used to consider some topics in greater detail through a rolling programme of 'deep dives'. It was suggested that workforce deep dives could also take place at the QSC meetings.

Consequently, the agendas of the QSC and FPC were reviewed and revised annual cycles were implemented from September 2019 reflecting the discussions and recommendations referred to above. It is recommended that the effectiveness of these arrangements continues to be monitored over 2019/20.

NHSI meeting observations

Colleagues from NHSI attended the February 2019 meeting of the QSC to observe the meeting. They provided helpful feedback, highlighting aspects that worked well and aspects that they considered could be improved. The feedback recognised the initial thoughts of the Committee on ensuring due attention was paid to the priorities regarding quality and safety as well as the workforce agenda. Additionally, they highlighted the volume of papers as an area where improvements could be made. They suggested it would be helpful for the Committee to consider which papers are provided for information only and which are required to gain specific assurances. It is recommended that further work takes place to ensure this aspect of the feedback is also addressed.

QSC Member Survey

The efficacy of the Committee has also been assessed by sending a questionnaire to Committee members and others who regularly attend the meetings. A total of 4 responses were received. The key findings under each question are detailed below.

Do you think the agenda covers the right items?

The respondents mostly agreed that the agenda covers the right items.

Do you feel that enough time is left for discussion?

The respondents mostly agreed enough time was left for discussion, though some thought this was not always the case.

Are discussions summarised and is the conclusion clear?

The respondents felt this was usually the case.

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

Strategically managing risk:

Most respondents agreed this was mostly achieved.

Ensuring compliance:

Most respondents agreed this was mostly achieved.

Improving quality:

The respondents agreed that this was achieved.

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

All respondents agreed that they felt able to challenge the Trust at the meetings.

How do you feel the Committee has performed against the areas identified for improvement in last year's annual review (listed below)? Please provide examples.

1. To continue to work on ensuring that the length of discussions is proportionate to the level of risk.

The responses to this question were mixed, but it was generally felt that there had been some improvement.

2. To continue to work on shortening reports and ensuring executive summaries are focussed on the key points only.
Most respondents felt that there was room for further improvement against this recommendation.

How has the Committee added value to the Trust's operations over the last year?
Respondents cited the high level of engagement from senior staff in relation to the quality agenda and the support and challenge at the meetings between the NEDs and Executive Directors. The presentations from the Divisional teams were also highlighted as a useful means of improving the connections between ward and Board.

Any other comments as to how the Committee's effectiveness could be improved?
Comments included:

- Respondents expressed support for the work taking place to review and restructure the agenda and meetings and highlighted the need to continue to monitor implementation
- It was suggested that there could be greater focus on how the organisation is learning form quality and safety themes
- It was suggested that changes to the committee could be enacted more quickly.
- There was also a suggestion that greater consideration should be given to the purpose of reports presented to the Committee.

Key duties and responsibilities of the QSC:

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

Managing Risk

The Committee has continued to consider the BAF and risk register report on a monthly basis, suggesting amendments to the entries and issues to escalate as appropriate.

The QSC has been kept informed of the outcome of the previous CQC inspection in 2018 and actions the Trust has taken to address the issues identified, as well as preparations for the Trust's 2019 inspection.

The Committee has also been kept informed of fire, estates and facilities compliance matters, receiving regular update reports throughout the year. The reporting structures for fire compliance were restructured during the year.

Emergency Preparedness and Resilience reports have also been considered by the Committee on a regular basis providing assurance regarding the Trust's ability to respond to a business continuity incident.

The QSC received a presentation from each division which included details of divisional objectives, governance structures, quality, safety and risks. Any significant issues were highlighted to the Trust Board through the QSC summary reports.

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

The QSC has continued to maintain a focus on key risk areas from a patient safety perspective, including falls, pressure ulcers, safeguarding, drug control and administration and health and safety.

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

The Committee received monthly updates on nurse staffing levels. The Committee also considered the two biannual nursing establishment reviews before they were considered by Trust Board for final approval.

Throughout the year, the QSC has received a monthly update regarding the Trust's clinical harm review process.

Ensuring Compliance

Throughout 2018/19 the QSC has continued to monitor the Trust's compliance with Care Quality Commission (CQC) standards.

The Trust faced some challenges regarding infection prevention and control in 2018/19 and the QSC was kept updated of these challenges and the actions that were taken to address them, including seeking the support of NHSI in undertaking audits of certain areas. The actions that were taken resulted in a much improved performance by the end of the year.

The QSC has continued its role of reviewing and endorsing the annual responsible officer's report regarding medical staff revalidation, prior to submission.

Through the reports scheduled on the annual cycle the QSC has ensured that it monitors compliance with a range of regulations and standards on a periodic basis, including infection prevention and control, fire safety, controlled drugs and medical devices. The QSC has also reviewed and approved a number of annual reports including the Gender Pay Gap Report, Engagement Annual Report, Security Annual Report and Research and Development Annual Report.

Improving Quality

2018/19 saw significant developments in relation to the quality agenda within the Trust and the QSC has been kept appraised of this work since the outset. This work began with the launch of the Trust's quality transformation programme in the autumn of 2018 and culminated in the development of a quality strategy which was endorsed by the QSC in March 2019, prior to approval by the Trust Board in April. The QSC has received regular updates on the progress of the work, and since March 2019 has been receiving a regular deep dive into the work programmes on a rolling cycle.

The Committee received regular updates from the maternity team regarding their work to show compliance with the 10 safety actions for the Clinical Negligence Scheme for Trusts NHSR Maternity Incentive Scheme-Year 2. The final submission, submitted in August 2019, showed that the Trust was compliant with all 10 of the safety actions.

The QSC received the annual report of the formal arrangement with the University of Hertfordshire which afforded the Trust University Status. The Committee noted progress on the priority work streams which report into the Joint Management Committee.

The QSC has continued to closely monitor the Trust's mortality rates, which performed well during the period, receiving a quarterly Learning from Deaths report, as well as regular

updates through the IPR from January 2019. There is a delay in the reporting of the Hospital Standardised Mortality Ratio (HSMR) and Standard Hospital Mortality Index (SHMI) but the HSMR for the data period January 2018 to December 2018 was 93.01 (statistically 'better than expected') and the SHMI for the same period was 94.1 ('as expected'). The Committee has also scrutinised mortality outliers and the on-going work to improve mortality.

The Committee was kept informed of the work the Trust undertook in relation to the Learning from Deaths national requirements and also in relation to the implementation of 7 day working.

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

The QSC has also continued to closely monitor complaints data, including response times and the common categories for complaints. The Committee have also reviewed the feedback from external surveys regarding patient experience. Complaints response times have not been meeting the target and the QSC have sought assurance from the Director of Nursing that these will improve and received updates on the improvement plans that have been implemented.

The QSC has maintained its role in relation to overseeing production of the Trust's Quality Account; supporting the draft document in January 2019 and agreeing for nominated representatives from the Committee to approve the release of the draft report to stakeholders, prior to final approval at the Trust Board meeting on 23 May (subject to any final comments from the External Auditors once the External Auditor report had been received).

The QSC has considered the results of the staff survey and discussed the initial action plan that was developed in response. (Monitoring of the implementation of the action plan was then taken forward by the FPC.)

The Quality and Safety Committee also reviewed and commented on the Trust's Clinical Strategy 2019-2014 prior to approval by the Trust Board in January 2019.

Reporting Arrangements

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

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

Conclusion

The review has not highlighted any material issues. It concludes that the QSC has met its duties under its terms of reference. It also recognises that there has been a recent change to the meeting structure and duties of the Committee in relation to workforce reporting and consideration of deep dives, which it is recommended continues to be monitored for the remainder of the year.

The Committee's terms of reference have been reviewed and the proposed amendments are highlighted in Appendix 1. These are primarily to clarify the duties and responsibilities of the QSC in relation to workforce matters.

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

- To continue to monitor the new meeting structure and workforce reporting over the course of the year, allowing for further review and adjustments to take place if required.
- To ensure the Committee is clear of the purpose of the reports it considers.
- To continue to encourage succinct and focussed reports and discussions at the meetings to ensure that there is sufficient time to cover the agenda items.

The Committee is asked to:

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

East and North Hertfordshire NHS Trust

QUALITY AND SAFETY COMMITTEE
TERMS OF REFERENCE

1. Purpose

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

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

2. Status and Authority

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

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

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

3. Membership

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

Core Attendees

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

Other attendees:
Chief Pharmacist
Associate Director of Quality and Safety

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

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

4. Quorum

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

5. Frequency of Meetings

The Committee will normally meet monthly. The Committee intends to alternate between holding a meeting that is focussed on a series of deep dives and one that considers regular reports and updates. These meetings will be flexed during the year if required. The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

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

6. Duties

Managing Risk

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

- To work with the Audit Committee when appropriate, and specifically in agreeing the Annual Internal Audit plan and providing a review of effectiveness on the clinical audit.

Ensuring Compliance

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

Improving Quality

- To endorse and monitor the implementation of the Trust's ~~four~~ key quality strategies~~: Risk Management Strategy, Patient Safety Strategy, Improving Clinical Outcomes Strategy and Patient Experience and Carer Strategy~~, including the Risk Management Strategy and Quality Strategy.
- To receive regular reports from the Trust and Divisions on Patient Safety and Clinical Quality and Outcomes ensuring appropriate action is taken
- To receive regular reports from the Trust and Divisions on Patient Experience Indicators ensuring appropriate action is taken
- To receive regular reports from the Trust and Divisions on Nurse/Patient Indicators and safer staffing ensuring appropriate action is taken
- To support the implementation of quality improvement programmes
- To be advised of the progress of any major quality initiatives in the Trust
- To receive regular reports on Learning, Education and Talent Management, Health and Wellbeing, Organisation Culture, clinical staffing establishment requirements and the report of the Guardian of Safe Working Hours. ~~Equality and Diversity, Organisational Cultural Development Programme (LEND), Revalidation and Professional Training ensuring appropriate action is taken.~~
- To consider a series of deep dives on key workforce areas, liaising with the Finance, Performance and Workforce Committee where appropriate.
- To monitor the quality and safety performance metrics.
- To monitor the delivery of the annual plan and receive the annual report from the Joint Management Group in relation to the Trust's partnership with the University of Hertfordshire.

7. Reporting arrangements

The Committee will provide a report of each meeting to the Trust Board. ~~Under the bimonthly schedule of Trust Board meetings, the RAQC report to Board will cover~~

~~more than one meeting when required or alternatively a report will be provided to the next Board Development meeting.~~
It will make recommendations to the Board, Executive Team and Executive Directors for these groups/individuals to take appropriate action.

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

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

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

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

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

9. Support

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

East and North Hertfordshire NHS Trust

Agenda Item: 12

TRUST BOARD - PUBLIC SESSION – 6 NOVEMBER 2019

AUDIT COMMITTEE – MEETING HELD ON 28 OCTOBER 2019
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present the summary report from the Audit Committee meeting of 28 October 2019 to the Trust Board. The report includes details of any decisions made by the Audit Committee under delegated authority.		
Action required: For discussion		
Previously considered by: **N/A**		
Director: Chair of Audit Committee	**Presented by:** Chair of Audit Committee	**Author:** Trust Secretary / Corporate Governance Officer

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) N/A
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

AUDIT COMMITTEE MEETING - 28 OCTOBER 2019

SUMMARY REPORT TO TRUST BOARD MEETING HELD ON 6 NOVEMBER 2019

The following Non-Executive Directors were present:

Jonathan Silver (Chair), Bob Niven, Karen McConnell (by phone).

MATTERS REFERRED TO BOARD:

Review of Trust Standing Orders and Standing Financial Instructions

The Committee considered the annual review of the Trusts' Standing Orders (SOs) and Standing Financial Instructions (SFIs), which regulate the way in which the proceedings and business of the Trust will be conducted. The review identified some minor amendments required to the information on the Board Committees, procurement sections and detailed limits of delegated authority.

The Committee recommended the revised SOs and SFIs to the Board for approval.

Audit Committee Annual Review 2018 -19

The Committee considered the annual review of the Audit Committee. This review concluded that the Committee met its duties under its terms of reference in the period. Some minor changes to the terms of reference were suggested.

A survey was circulated to Audit Committee members in order to incorporate their thoughts in the review. The feedback from Committee members and attendees was positive and the review did not identify any recommendations for improvements that were not already underway.

The Committee discussed the findings of the effectiveness review, recommended the amended terms of reference and approved the annual review for submission to the Board.

Charity Annual Report and Accounts

The Trust Charitable Fund Audit Completion Report for the year ended 31 March 2019 was submitted to the Committee. The report summarised the results completing the planned audit approach for the year ended 31 March 2019, specific audit findings and areas requiring further discussion and/or the attention of the Audit Committee.

It had not been possible to create a final version of the annual report and the accounts before the Committee meeting. It was agreed that these would be circulated to the members of the Audit Committee and the Charity Trustee Committee for approval before the 6 November Trust Board meeting.

The external auditors discussed the results of their audit of the financial statements with the committee. They anticipated issuing an unmodified audit opinion on the financial statements.

They reported that issues had been identified in the treatment of legacies. The financial statements had been amended in response to these issues. They also recommended that the amount recharged to the Charity by the Trust be reviewed from 2019/20 as outdated information was currently being used.

OTHER:

Cyber Security Report

The Committee considered the latest Cyber Security Report. The report was submitted to provide awareness of the Trust's cyber security position, highlight any risks or threats and inform the committee of the work done to protect and secure the Trust.

The Data Security Officer reported that the current alert status was at medium. All 'High' open actions had been closed. He reported on the progress that had been made from August to October 2019 and on actions scheduled for November 2019 to January 2020.

Board Assurance Framework and Risk 01/19 Deep Dive

The Associate Director of Corporate Governance presented the latest version of the Board Assurance Framework 2019 -2020 and the risk update report which described progress with implementing the Risk Management Strategy and the Risk Management Implementation Plan (RMIP). The RMIP detailed the steps taken to get all parts of the Trust to routinely identify, discuss, control and escalate risks. The risk register status, KPIs and RMIP demonstrated that good progress was being made.

The Associate Director of Corporate Governance reported that the outcome of the CQC and use of resources reports were anticipated in November 2019. The Committee discussed the findings of the recent HSE inspection. The Trust had received three HSE improvement notices which had to be responded to by January 2020. An action plan was being developed.

The Committee considered a deep dive of the performance capacity risk and in particular, the report showed that there has been a comprehensive level of work taken forward to mitigate this risk and address performance and capacity issues across cancer, RTT, ED and Diagnostics.

Internal Audit Progress Report

The report provided the Committee with a summary update on the internal audit plan for 2019/20 which was approved by the Audit Committee in March 2019 and summarised the results of work done to date. Six reports had been finalised since the last meeting as follows:

Data Quality, Integrated Performance – Partial Assurance Opinion

Vacancy Authorisation – Reasonable Assurance Opinion

Consultant Job Planning - Partial Assurance Opinion

Surgery Divisional Governance - Reasonable Assurance Opinion

Clinical Capacity and Utilisation Governance - Partial Assurance Opinion

Pseudonymisation Audit - Partial Assurance Opinion

Four audits (Management of Sickness Absence, Radiology Utilisation, Theatre Productivity – Governance Arrangements and Pay Budget Setting) had been issued in draft.

The Committee discussed the audits which had received partial assurance opinions. The issue of consultant job planning was discussed, including that job plans and budgeting for capacity should not be independent of each other and it was agreed that the Medical Director would report to a future meeting on this issue.

Local Counter Fraud Specialist Progress Report

The Counter Fraud progress report was presented to provide an overview of the key pieces of work undertaken as part of the counter fraud work plan since the last audit committee; to provide a summary of the reactive referrals received and investigations pursued and to outline the progress against management actions.

With regards to investigations, an invoice of £1,714.92 had been issued to a former employee to recover an overpayment of occupational sickness pay, deemed ineligible following conduct of working whilst sick. Two additional referrals were noted since the report was published.

Recommendation Tracking Report

The report showed the latest updates in respect of recommendations made. 60% (31) of recommendations had been implemented, 15% (8) were overdue by 0 – 3 months, 4% (2) were overdue by 3 – 6 months, 13% (7) were overdue by 6 + months and 8% (4) were not yet due.

Progress has been made with 31 actions having been closed since the last Audit Committee meeting.

IA benchmarking / Reports for information

The Internal auditors provided the Trust with the following documents for information:

Healthcare Benchmarking report 2018/19, and

September 2019 edition of Health matters.

Learning and Feedback from 2018/19 External Audit

The report was submitted to report on lessons learned from the external audit 2018/19.

The report set out the positive aspects of the 2018/19 audit process and identified improvements for future years. The Committee noted the report.

Data Quality and Clinical Coding Report

The Head of Data Quality presented the report to inform the Committee of progress on data quality improvements and clinical coding activities. She detailed the projects that the Data Quality and Clinical Coding teams had been involved with during the last three months.

The Data Quality team had been involved in the following projects:

- Access Plan Project - cleaning up old legacy plans and training staff to reduce duplications and idle plans;
- Data Quality Compendium (DQC) - the need for a deep dive into each service;
- Consultant Master File - to eliminate duplicate consultant entries and increase probability of activity recorded against correct consultant.

The Committee noted the timelines for the projects and that the recent focus on improving discharge summary performance had slowed progress on these projects to some extent.

Fixed Asset Verification Progress Report

The Deputy Director of Finance presented a progress report on the verification of fixed assets. He reported that the verification of intangible assets, IT hardware, furniture and fittings and plant and machinery was complete. Consent was sought for the write-off of a number of items which were no longer in use. The Committee supported the write-off.

The report indicated that the full asset verification exercise would be complete by 31st March 2020.

IFRS 16 Implementation Update

The report was submitted to inform the Committee about an update to the IFRS. IFRS 16 Leases was a new accounting standard which was being applied by HM Treasury from 1 April 2020. The report provided a review of the estimated impact of the new standard on the Trust's accounts with effect from 2020-21 annual accounts.

Conflicts of Interest and Gifts and Hospitality Registers

The Committee received an update regarding the Trusts' Conflict of Interest processes. Due to the extension of the Trust's Managing Conflicts of Interest Policy to a wider pool of staff than was previously the case, the task of administering the register had grown considerably and the current manual system was a challenge to maintain. From March 2020, the national NHS Electronic Staff Record (ESR) would include a function for recording conflicts of interest which should address these issues.

The Committee noted the update provided regarding the Trust's processes for managing conflicts of interest, approved the Gifts and Hospitality Register for approval prior to publication and noted the extract from the Conflicts of Interests Register regarding Board members.

Jonathan Silver
Non-Executive Director
October 2019

East and North Hertfordshire NHS Trust

Agenda Item: 12.1

TRUST BOARD - PUBLIC SESSION – 6 NOVEMBER 2019

Audit Committee Annual Review

Purpose of report and executive summary (250 words max): This report provides the findings of the annual review of the Audit Committee. The review concludes that the Committee met its duties under its terms of reference. The feedback from Committee members and attendees was positive and the review has not identified any recommendations for improvements that are not already underway. The terms of reference have been reviewed and some minor changes are suggested. The proposed amendments are highlighted in Appendix 1. The Board is asked to approve the amended terms of reference and annual review.		
Action required: For approval		
Previously considered by: **Audit Committee – 28 October 2019**		
Director: **Director of Strategy**	**Presented by:** **Chair of Audit Committee**	**Author:** **Trust Secretary**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) Not directly
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

AUDIT COMMITTEE
ANNUAL REVIEW 2018/19

Executive Summary

The Audit Committee is a key assurance committee of the Trust Board. Its purpose is to provide an independent and objective review of the Trust's system of internal control, including its financial systems, financial information, assurance arrangements including clinical governance, approach to risk management and compliance with legislation.

This annual review considers how the Audit Committee has met its duties under its terms of reference. The findings of this review are based on a review of the Committee's minutes and its reports to the Board, the Annual Governance Statement 2018/19, a review of the Trust's Standing Orders and Scheme of Delegation and the findings of a survey of Audit Committee members and regular attendees.

This review concludes that the Committee met its duties under its terms of reference. The feedback from Committee members and attendees was positive and the review has not identified any recommendations for improvements that are not already underway.

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

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

Summary of Key Findings

- **Meetings and Membership**

The Audit Committee met formally on five occasions during 2018/19 (with the final meeting of the period held on 1 April 2019) and also held an extraordinary meeting on 23 May 2019 to review the Trust's annual report and accounts. All of the meetings were quorate.

The membership of the Committee changed during the course of the year, with Mrs Karen McConnell replacing Mr Nick Swift as a member of the Committee. Mr Swift left the Trust in October 2018 and Mrs McConnell joined the Trust in January 2019. Mr Jonathan Silver remained as Chair of the Audit Committee and Mr Niven remained a member of the Committee throughout the period.

The Associate Director of Corporate Governance and Director of Finance (regular attendees at the meetings of the Audit Committee) remained in post throughout 2018/19. The Chief Executive attended the meeting in May 2019 when the Annual Governance Statement and the annual report and accounts were considered.

The Committee met in private with the external auditors as part of the extraordinary meeting in May 2018. Whilst the Committee did not formally meet in private with the auditors again during 2018/19, the Audit Committee Chair was in contact with the auditors throughout the period and in advance of the meetings.

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

- **In-year Changes**

The AC has been proactive in-year, considering how it could make improvements to its effectiveness and, in agreement with the Chairs of other committees, making some adjustments to the reports it considers.

Towards the start of the year, the Committee agreed to take on responsibility for oversight of Data Quality and Clinical Coding, Sustainability and Guarding of Safe Working Hours Report from the Finance and Performance Committee in order to alleviate some pressure from the FPC's workload. Following consideration of the Guardian of Safe Working Hours Report, the AC suggested that the Quality and Safety Committee would be better placed to maintain oversight of this particular issue due to the link to quality and safety. This amendment is reflected in the updated terms of reference (Appendix 1).

The Committee has also been proactive in considering how to gain assurance in terms of the Trust's risk management processes and increase oversight in this area. The AC reviewed the BAF at each meeting from July 2018, considered the draft Risk Management Strategy 2019-20 and, since July 2019, has requested that the Committee considers deep dives into a selection of the BAF risks over the course of 2019/20. The initial deep dive looked at the capital risk and the link to estates and facilities risks.

- **Committee Survey**

The efficacy of the AC has been assessed by issuing a questionnaire to Committee members and others who regularly attend the meetings. There were a total of four responses to the survey. A summary of the findings are provided below:

- The respondents agreed that the agenda covers the right items.

- The only suggestion for extending the extent of the Committee's work was a greater focus on risk management.
- All respondents agreed that the right individuals are at the meetings
- The respondents mostly agreed that there was sufficient time for discussion on individual agenda items.
- All respondents agreed that they felt able to challenge the Trust at the meetings.
- In terms of improving the quality of discussions, the suggestions included greater involvement of the responsible line managers and providing greater assurance on risk management
- The respondents felt that the Audit Committee had added value to the Trust's operations over the last year through effective scrutiny and challenge on various issues, including financial management and implementation of internal audit actions.

There were few suggestions as to how the Committee's effectiveness could be further improved. It was suggested that there was further scope for the Trust to improve on the implementation of the auditors' recommendations and also for greater focus on risk management – both issues which the Committee is already working to address.

The responses regarding the recommendations identified in last year's annual review are detailed in the following section of this report.

On the whole, the responses received were positive regarding the efficacy of the Committee.

➢ **Areas for improvement highlighted in 2017/18 Annual Review**

The following table details the areas identified for improvement in the 2017/18 annual review and details how those recommendations have been addressed:

	Areas for improvement	Addressed by
1.	For the Audit Committee to maintain a greater focus on risk management	The Committee has considered the BAF at every meeting since July 2018. Additionally, the Committee has recently begun to undertake deep dives into the BAF risks. The respondents to the survey recognised the process in place but there was some feedback that there was room for further improvement.
2.	For further work to take place on improving the quality of reports	The Chair has liaised with the internal auditors regarding the content of their reports and Trust reports have attempted to provide succinct summaries of the key points. The respondents mostly felt that the quality of reports was of a good standard.
3.	To continue to invite the lead director to attend for 'no assurance' and 'partial assurance' internal audit reports.	This practice continued throughout 2018/19. The respondents recognised this, though there was a suggestion that greater engagement with responsible line managers could also be beneficial.

How the Committee has met its responsibilities, as set out in the terms of reference:

- **Governance, Risk Management and Internal Control**

The Audit Committee received the latest version of the Board Assurance Framework at every meeting from July 2018, as well as regular updates regarding the implementation of the Trust's Risk Management Strategy. Responsibility for scrutiny of the individual risks recorded on the BAF was assigned to either the Quality and Safety Committee or Finance and Performance Committee, depending on the nature of the risk, whilst the Audit Committee was concerned with monitoring the process and systems of risk management as a whole. In April 2019 the Audit Committee considered the draft Risk Management Strategy 2019-20. The updated strategy now included the risk escalation process that had been implemented during the year and also information regarding the Trust's risk appetite. The new strategy was endorsed by the Board in May 2019. Additionally, since the July 2019 meeting, the Audit Committee has been undertaking a deep dive into one the BAF risk entries at each meeting.

In May 2018 the AC reviewed and endorsed the final draft of the Annual Governance Statement 2017/18 which was submitted to the auditors as part of the Trust's Annual Report and Accounts submission. Following discussion, the Audit Committee supported the conclusion 'No significant internal control issues have been identified'. In May 2019, the Committee recommended the Annual Governance Statement 2018/19 for approval by the Trust Board. Again, the report concluded that there were no significant control weaknesses.

As part of its governance responsibilities, the Audit Committee reviewed the declarations of interest and gifts and hospitality register for the period to October 2018. The policy had been updated the previous year and the number of declarations had increased considerably under the new policy.

The Audit Committee was informed of the work that had taken place to prepare the Trust for the implementation of the General Data Protection Regulation in May 2018, receiving assurance on the Trust's compliance with the new regulation.

Key policies approved by the Audit Committee included:

- Risk Management Strategy
- Capital Asset Disposal Policy
- Treasury Management Policy

- **Internal Audit**

The Committee received regular progress reports from its internal auditors (RSM UK) on internal audit work undertaken during 2018/19. The audits received by the Committee over the year covered areas including effective rostering of locums, financial planning process, CQC compliance, discharge management and data quality.

The Committee discussed in more detail the audits that received only a 'partial assurance' opinion, often inviting the lead director to the meeting to discuss the findings. There were no 'no assurance' opinions issued during the year.

The internal audit work plan for 2019/20 was approved the Committee in April 2019, following consideration by the Executive Committee and Quality and Safety Committee.

At the May 2019 meeting, the Committee received the Head of Internal Audit's Opinion for 2018/19. The opinion was:
'The organisation has an adequate and effective framework for risk management, governance and internal control.'

The Committee continued to closely monitor completion of actions arising from audits, recognising that this was a key mechanism for internal audits to add value to the Trust's operations. In response to challenge from the Audit Committee, consideration of the internal audit actions now takes place at the Executive Committee meetings on a regular basis. Whilst the Audit Committee has been pleased by the improvement over the year, it considers that there is further room for improvement and continues to monitor performance into 2019/20.

- **External Audit**

The Committee worked closely with the Trust's external auditors (BDO) on the external audit of the Trust's annual report and accounts 2018/19.

The Trust's annual accounts 2018/19 and EA report on the year-end accounts were considered at the Audit Committee meeting held on 23 May 2019. At that stage, the AC were informed that minor changes were possible once the external audit was finalised but the substance and materiality would not be changed. The external auditors had identified an issue with the treatment of some costs relating to training (concerning a sum in the region of £0.5m). The External Auditors advised the AC that they intended to add a note to the letter of representation explaining the position. The Audit Committee were satisfied with this approach as the amounts involved were not material overall. Consequently, the Audit Committee recommended the final accounts for 2018-19 for approval by the Trust Board at an extraordinary meeting held later that day.

As well as undertaking the audit of the Trust's accounts, the external auditors also undertake an audit of the Trust's Quality Account each year. For 2018/19 the timelines for internal approval of the Quality Account were aligned with the audit of the accounts. The Audit Committee considered the final draft of the Quality Account at the meeting on 23 May and it was approved by the Trust Board at its meeting later that day, subject to any final changes required as a result of the final completion of the External Auditor's work.

The Committee also received updates regarding the Trust Charity and ENH Pharma Ltd accounts. The audits of the Charity accounts 2018/19 are due to be completed in October 2019. The ENH Pharma accounts are consolidated into the Trust accounts. The external audit of the ENH Pharma accounts will be completed in October / November 2019.

- **Other Assurance Functions**

Other assurance functions undertaken by the Audit Committee in 2018/19:
- The Committee received updates regarding the Trust's sustainability development management strategy. Recognising it will be challenging to achieve the targets given the current performance level, the Committee continues to keep a keen interest in this area in 2019/20.
- The Committee has received regular updates from the Data Quality and Clinical Coding teams, reviewing the draft strategy in October 2018 and receiving updates regarding its implementation since.
- The Committee has also continued to seek assurance regarding cyber security, receiving regular updates detailing actions in relation to cyber security and providing robust challenge where actions have not been achieved.

- The Committee received twice-yearly reports regarding the Trust's significant losses/special payments.
- The AC received updates regarding the Trust's current position regarding Freedom to Speak Up work and work to develop an open culture, as well as the raising concerns log.
- The Committee reviewed and recommended to the Trust Board the annual review of the Trust's Standing Orders and Standing Financial Instructions.
- For much of 2018/19, responsibility for monitoring compliance with the obligations relating to the Guardian of Safe Working Hours was included within the Audit Committee's terms of reference. The Committee received the reports and requested follow up actions to better understand the data. The report is now considered by the Quality and Safety Committee.

- **Counter Fraud**

The Audit Committee continued to monitor the work of the Local Counter Fraud Specialist (LCFS) throughout the year, a service provided by the Trust's internal auditors.

The AC received a regular LCFS progress report at its meetings throughout the year, detailing the work of the LCFS. The issues discussed over the course of the year included counter fraud referrals, fraud arising from overseas patients and the development of a bespoke fraud risk register for the Trust.

The AC approved the LCFS work plan for 2019/20 at the meeting in April 2019.

In May 2019 the AC received the Local Counter Fraud Specialist Annual Report for the period 2018/19. The report provided an annual summary against the NHS Counter Fraud Authority's anti-fraud standards, based upon and limited to the work performed by the LCFS in line with the agreed annual work plan. The self-review tool for the period resulted in an overall rating of amber. Action points have been developed to address the actions that were rated as red or amber and the AC has continued to monitor progress against these into 2019/20.

- **Management**

The Committee continued to request attendance by the relevant director or senior manager whenever it considered a report provided less than adequate assurance and received specific reports from individual functions within the organisation (such as IM&T and clinical audit) relating to overall arrangements for governance, risk management and internal control.

- **Financial Reporting**

One of the key duties of the Audit Committee is to review the annual report and accounts before submission to the Board. The Committee undertook this role at its meeting in May 2019, recommending the reports for approval by the Trust Board at the Trust Board meeting which followed later that day.

- **Reporting Arrangements**

The Audit Committee has provided an executive summary report to the Trust Board after each meeting which has highlighted the key issues to the Board.

Conclusion

This review concludes that the Committee met its duties under its terms of reference. The feedback from Committee members and attendees was positive and the review has not identified any recommendations for improvements that are not already underway.

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

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

Appendix 1

AUDIT COMMITTEE TERMS OF REFERENCE

Purpose

The purpose of the Audit Committee is to provide an independent and objective review of the Trust's system of internal control including its financial systems, financial information, assurance arrangements including clinical governance, approach to risk management and compliance with legislation.

Status and Authority

The Audit Committee is established as a formal committee of the Board. It is a non-executive committee and has no executive powers other than those specifically delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Membership

Three Non-Executive Directors (excluding the Chair of the Trust Board), one of whom shall be appointed Chair by the Board.

Quorum

Any two members of the Committee are required to be present.

Attendance

The Director of Finance, the ~~Company Secretary~~Associate Director of Corporate Governance, and appropriate internal and external audit representatives shall normally attend meetings. At least once a year the Committee will meet privately with the external and internal auditors.

The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement (AGS). He or she should also attend when the Committee considers the draft internal audit plan and the annual accounts. Other executive directors should be invited to attend, particularly when the Committee is discussing the areas of risk or operation that are their responsibility. Other senior managers may be required to attend as needed.

Frequency of Meetings

The Committee will consider the appropriate frequency and timing of meetings to allow it to discharge all its responsibilities, but it will not meet less than five times

during the year. The external auditors or Head of Internal Audit may request a meeting if they consider that one is necessary.

Duties

The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

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

In particular, the Committee will review the adequacy of:

- the policies and processes for preparing the Board Assurance Framework including the quality of the evidence for assurance provided by Internal and External Audit, management and other sources
- to review and monitor the Board Assurance Framework
- all risk and control related disclosure statements (in particular the AGS), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions to test the effectiveness of the framework, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework

- consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- an annual review of the effectiveness of internal audit

External Audit

The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit
- discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy
- discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (eg the Care Quality Commission, etc) and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies, etc).

The Committee will also undertake the following additional duties:

- To approve the Data Quality Strategy and monitor delivery against the indicators,
- To approve the Trust's Sustainability Development Management Strategy and plan and monitor progress to ensure national requirements are met,
- ~~To monitor compliance to ensure the Trust meets its obligations under the Guardian of Safe Working.~~

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this will include the Quality and Safety (QSC), the Finance, ~~and~~ Performance and Workforce Committee (FPC), and the Charity Trustee Committee (CTC).

In reviewing the work of the Quality and Safety Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (eg clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Audit Committee shall review the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- the wording in the AGS and other disclosures relevant to the terms of reference of the Committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted mis-statements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letter of representation
- qualitative aspects of financial reporting.

Reporting Arrangements

Following each meeting, the Audit Committee will submit a report to the Board~~, using the approved reporting form~~. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board at least annually on its work in support of the AGS, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the Quality Account.

Process for Review

The Committee will complete an annual review of its terms of reference and conduct a self-assessment of its effectiveness on an annual basis, in line with the requirements of the Audit Committee Handbook.

Support

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

East and North Hertfordshire NHS Trust

Agenda Item: 12.2

TRUST BOARD - PUBLIC SESSION – 6 NOVEMBER 2019

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

Purpose of report and executive summary (250 words max): To present annual review of Trust's SFIs to the Board for approval. This review has identified some minor amendments required to the information on the Board Committees, procurement sections and detailed limits of delegated authority. The changes are noted on tracked changes for ease of reference. The Audit Committee have considered and endorsed the changes.		
Action required: For approval		
Previously considered by: Audit Committee, October 2019.		
Director: **Director of Finance**	**Presented by:** **Chair of Audit Committee / Director of Finance / Associate Director of Corporate Governance**	**Author:** **Deputy Director of Finance/ Associate Director of Corporate Governance/ Financial Controller/ Trust Secretary/ Counter Fraud**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) **Aligns to Governance and Financial BAF risks.**
Any other risk issues (quality, safety, financial, HR, legal, equality): There is a risk to the financial performance of the Trust if there is not a robust governance process in place. The Trust is required to have Standing Orders, Standing Financial Instructions and a Scheme of Delegation as part of its constitution.

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

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

1. Introduction

1.1 Attached to this paper are the standing orders, reservation and delegation of powers and standing financial instructions with proposed amendments.

1.2 NHS Trusts are required by law to make Standing Orders (SOs) and Standing Financial Instructions (SFIs), which regulate the way in which the proceedings and business of the Trust will be conducted and this should be reviewed regularly to keep them up to date.

1.3 This revision has arisen as a result of the requirement to carry out an annual review.

1.4 This review has identified some minor amendments required to the information on the Board Committees, procurement sections and detailed limits of delegated authority.

1.5 The Audit Committee reviewed and endorsed the changes for final Board approval.

2. Key changes

Below are the key amendments to this document and a reference to sections updated

Section	Key changes
Various	Company Secretary to Trust Secretary
4.8.4 Committees	Updated purpose of the Board Committees in line with the 2019 reviews of the Terms of Reference
17.6.4 Procurement	This section has been updated to reference the Department of Health's Estates and Facilities guidance on capital works.
17.7.7 Procurement: Invitation to tender – Electronic Process	Updated to reflect the new e tender process.
Appendix 2 Detailed Limits of Delegation Policy	The approval limits has been reduced to include budget managers from Band 7 and above to enable them to be able to approve low value invoices where procurement has been approved by Discretionary Review Panel or management. This will reduce the delay to invoice approval currently experienced as a result of many invoices going to senior management for approval. It will also ensure budget managers who know about the purchase are able to approve invoices provided it's within their approval limits.
Scheme of delegation from SOs and 26.2.2 – Losses and Special Payments	Updated to reflect NHS Counter Fraud Authority *(Updated post Audit Committee following feedback from Internal Audit*.

3. Recommendations

The Board is requested to approve the revision to the Standing Orders, Standing Financial Instructions and a Scheme of Delegation as illustrated in the appendix.

East and North Hertfordshire NHS
NHS Trust

TRUST-WIDE POLICY

for

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

A document recommended for use

In: Trust-wide

By: All staff

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

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

Written by: ~~Company Secretary~~ Associate Director of Corporate Governance
Financial Controller
~~Head of Procurement~~Director of Procurement
Local Counter Fraud Specialist

Approved by: Audit Committee

Mr Jonathan Silver (Committee Chair), 22 October 2018

Trust Ratification: Trust Board

Mrs Ellen Schroder (Trust Chair), 7 November 2018

Policy issued: November 2019~~8~~
To be reviewed before: November 2020~~19~~
To be reviewed by: Associate Director of Corporate Governance / Financial Controller
Doc Registration No. CG05 **Version No.** ~~8~~9

Version	Date	Comment
1	2010	
2	2012	
3	2013	Scheduled review: Updated to reflect the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation. Loss and compensation section updated. Delegated Limits reviewed.
4	October 2014	Scheduled review – Minor changes. Delegated limits reviewed.
5	October 2015	Scheduled review. Revised to reflect Capital Review Group Update to include revised process regarding centralisation of documents on the KC; improved escalation process and inclusion of a wider range of documents
6	October 2016	Scheduled review. Revised to ensure supports Board meeting moving to bi- monthly, include the Auditor Panel and strengthen procurement.
7	October 2017	Scheduled review. Updated in line with Organisational changes.
8	October 2018	Scheduled review. Updated in line with Organisational changes.
9	October 2019	Scheduled review. Updated in line with Organisational changes.

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

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

Associated Documentation
Managing Conflicts of Interest -Policy
Anti-Fraud and Bribery Policy
Trust Values & behaviours

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

Key messages

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

EAST AND NORTH HERTFORDSHIRE NHS TRUST

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

October 2018~~8~~9

CONTENTS (to be updated post audit committee)

CONTENTS (to be updated post audit committee)

Page

CONTENTS (to be updated post audit committee)

SECTION A

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

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

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

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

1.2.2 **Trust** means the East and North Hertfordshire NHS Trust

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.2.25 **SFIs** means Standing Financial Instructions.

1.2.26 **SOs** means Standing Orders.

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

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

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

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

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

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

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

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

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

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

1.2 NHS Framework

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

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

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

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is

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

1.4 Integrated Governance

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

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

2.1 Composition of the Membership of the Trust Board

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

(1) The Chair of the Trust (Appointed by NHS Improvement);

(2) Up to 5 non-officer members (appointed by the NHS Improvement);

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

- the Chief Executive;
- the Director of Finance

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

2.2 Appointment of the Trust's Chair and Members of the Trust

(1) Appointment of the Chair and Members of the Trust - National Health Service Act 2006 as amended by the Health and Social Care Act provides that the Chair is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Trusts Chair and members are set out in the Membership, Procedure and Administration Arrangements Regulations.

2.3 Terms of Office of the Chair and Members

(1) The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in Sections 2 to 4 of the Membership, Procedure and Administration Arrangements and Administration Regulations.

2.4 Appointment and Powers of Vice-Chair

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

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

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

2.5 Joint Members

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

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

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

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

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

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

2.6 Patient and Public Involvement

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

2.7 Role of Members

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

(1) **Executive Members**

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

(2) **Chief Executive**

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

(3) **Director of Finance**

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

(4) **Non-Executive Members**

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

(5) **Chair**

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

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

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

2.8 Corporate role of the Board

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

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

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

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

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

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated

into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.10 Lead Roles for Board Members

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

3. MEETINGS OF THE TRUST

3.1 Calling meetings

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

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

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

3.2 Notice of Meetings and the Business to be transacted

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

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

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

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

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

3.3 Agenda and Supporting Papers

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

3.4 Petitions

Where a petition has been received by the Trust the Chair shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

(1) Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

(2) The notice shall be delivered at least 5 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

Subject to the agreement of the Chair, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

i) **Who may propose**

A motion may be proposed by the Chair ~~Chair~~ of the meeting or any member present. It must also be seconded by another member.

ii) **Contents of motions**

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

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

iii) **Amendments to motions**

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

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

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

iv) **Rights of reply to motions**

a) Amendments

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

b) Substantive/original motion

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

v) **Withdrawing a motion**

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

vi) **Motions once under debate**

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

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion under Section l (2) or Section l (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press (see Standing Order 3.17).

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

If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

(1) Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

(2) When any such motion has been dealt with by the Trust Board it shall not be competent for any director/member other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chair of meeting

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

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

3.10 Chair's ruling

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

3.11 Quorum

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

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

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

3.12 Voting

(i) Save as provided in Standing Orders 3.I3 - Suspension of Standing Orders and 3.I4 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chair of the meeting shall have a second, and casting vote.

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

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

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

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

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

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

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

3.13 Suspension of Standing Orders

(i) Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 3.11),

any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Officer Member of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

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

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

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

3.14 Variation and amendment of Standing Orders

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

- upon a notice of motion under Standing Order 3.5;
- upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;
- that two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Officer members vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.15 Record of Attendance

The names of the Chair and Directors/members present at the meeting shall be recorded.

3.16 Minutes

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

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

3.17 Admission of public and the press

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

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

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

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

(ii) **General disturbances**

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

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

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

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

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

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

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

3.18 Observers at Trust meetings

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

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

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

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

4.2 Joint Committees

(i) Joint committees may be appointed by the Trust by joining together with one or more other NHSI, CCG, or other Trusts consisting of, wholly or partly of the

Chair and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

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

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

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

4.4 Terms of Reference

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

4.5 Delegation of powers by Committees to Sub-Committees

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

4.6 Approval of Appointments to Committees

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

4.7 Appointments for Statutory functions

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

4.8 Committees established by the Trust Board

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

4.8.1 **Audit Committee**

In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and more recently the Higgs report, an Audit Committee will be established and constituted to provide the Trust Board with an independent and objective review of the Trust's system of internal control including its financial systems, financial information, assurance arrangements including clinical governance, risk management and compliance with legislation. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis. Assurances with regards to the ongoing management of risk are within the duties of the Quality and Safety Committee.

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

4.8.2 **Remuneration and Terms of Service Committee**

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

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

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

(i) setting the Remuneration Policy for the Chief Executive, Executive Directors and staff on Trust Pay
(ii) all aspects of salary (including any performance-related elements/bonuses);
(iii) provisions for other benefits, including pensions and cars;
(iv) arrangements for termination of employment and other contractual terms;
(v) to review and approve the Remunerations Framework for subsidiary companies of the Trust.

4.8.3 **Charitable Trustee Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Trust Board will establish a Trust and Charitable Trust Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

The provisions of this Standing Order must be read in conjunction with Standing Order 2.8 and Standing Financial Instructions 29.

4.8.4 **Other Committees**

The Board may also establish such other committees as required to discharge the Trust's responsibilities. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

These currently include:

i) Finance, ~~and~~ Performance and Workforce Committee - ~~The purpose of the 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~~.

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

The Committee's work will include:

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

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

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

Please note the Trust's Audit Committee will ensure the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk and the Finance, Performance and Workforce Committee will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances QSC will provide scrutiny.~~The purpose of the Quality and Safety Committee will be to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, research governance, information governance, health & safety, patient and public safety, organisational culture and OD and compliance with CQC regulation. The Committee will also be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the strategic objectives and quality transformation plan.~~

iii) Auditor Panel - In line with the requirements of the Local Audit and Accountability Act 2014 the Trust has established an Auditor Panel to enable the Trust to meet its statutory duties by advising on the selection, appointment and removal of the External Auditors and on maintaining an independent relationship with them. The Terms of Reference are approved by the Trust Board and reviewed on a periodic basis. The committee is comprised of the Audit Committee Non-Executive Directors.

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 (NHSI) or Clinical Commissioning Group (CCGs) ;

(iii) by arrangement with the appropriate Trust or CCG, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;

(iv) in relation to arrangements made under S63(1) of the Health Services and Public Health Act 1968, jointly with one or more NHSI, NHS Trusts or CCG.

5.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or officers, the Trust delegating the function retains full responsibility.

5.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-officer members. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

5.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.3.2 When the Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance to provide information and advise the Board in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

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

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The Trust Board will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by East and North Hertfordshire NHS Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct and Conflicts of Interest Policy for East and North Hertfordshire NHS Trust staff;
- the staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 2010;

- Human Rights Act 1998;
- Freedom of Information Act 2000.

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to Board Members

i) The NHS Code of Accountability requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

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

7.1.2 Interests which are relevant and material

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

a) Outside Employment including Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies); Any other paid work including speaking at conferences, consultancy work and medico-legal work

b) Shareholdings and other ownership issues: Holding shares / other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might reasonably be expected to do, business with the Trust

c) Patents: Holding a patent and/or other intellectual property rights related to items to be procured or used by the Trust; Holding a patent and/or other intellectual property rights by virtue of your association with an organisation related to items to be procured or used by the Trust or On-going or new applications to protect related to items to be procured or used by the organisation.

d) Loyalty Interests: Position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions you take in your NHS role; Seat on an advisory group or other paid or unpaid decision making forum that might influence how the Trust spends taxpayers money; Involved in, or could be involved in, the recruitment or management of close family members and relatives, close friends and associates, and business partners and Aware that the Trust does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

e) Donations: Donation made by suppliers or bodies seeking to do business with the Trust or Donation from another body.

f) Sponsorship: Sponsorship of an event by an appropriate external body; Involvement with sponsored or External sponsorship of a post. ;

g) Clinical Private Practice: Existing private practice (declare on appointment); New private practice (declare as it arises) Interests in pooled funds that are under separate management.

h) Other e.g. Any relevant position held by a spouse, partner or family member; or any influence over recruitment, or management (or other oversight) over family members, close friends or spouse/partner

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

7.1.3 **Advice on Interests**

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

International Financial Reporting Standard (IAS 24) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 **Recording of Interests in Trust Board minutes**

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes.

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

7.1.5 **Publication of declared interests in Annual Report**

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

7.1.6 **Conflicts of interest which arise during the course of a meeting**

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

7.2 Register of Interests

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material

interests (as defined in SO 7.1.2) which have been declared by both executive and non-executive Trust Board members.

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

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

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

7.3.1 **Definition of terms used in interpreting 'Pecuniary' interest**

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

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

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

(iii) "Pecuniary interest"

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

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

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

iv) Exception to Pecuniary interests

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

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

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

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

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

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

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

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

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

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

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

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

(1) Power of the Secretary of State to make waivers

Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a Chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

(2) Definition of 'Chair' for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3.(3) (below), the "relevant Chair" is –

(a) at a meeting of the Trust, the Chair of that Trust;

(b) at a meeting of a Committee –

(i) in a case where the member in question is the Chair of that Committee, the Chair of the Trust;

(ii) in the case of any other member, the Chair of that Committee.

(3) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

(i) A member of the East and North Hertfordshire NHS Trust ("the Trust"), who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

(a) services under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation; or

(b) services in connection with a pilot scheme under the now the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation;

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

(ii) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:-

(a) arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(b) has been declared by the relevant Chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:–

(i) are members of the same profession as the member in question,

(ii) are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(4) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant Chair must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3 (2) (b) above, except where that member is the Chief Executive;

(c) **in the case of a meeting of the Trust**:

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may not vote on any question with respect to it.

(d) **in the case of a meeting of the Committee:**

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may vote on any question with respect to it; but

(iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.4 Standards of Business Conduct

7.4.1 **Trust Policy and National Guidance**

All Trust staff and members of must comply with the Trust's Values and Standards of Business Conduct and 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~~Trust Secretary as soon as practicable.

ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 **Canvassing of and Recommendations by Members in Relation to Appointments**

i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4.4 **Relatives of Members or Officers**

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

ii) The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

iii) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' (SO 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 **Custody of Seal**

The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him/her in a secure place.

8.2 **Sealing of Documents**

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

8.3 **Register of Sealing**

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 **Signature of documents**

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

9. MISCELLANEOUS (see overlap with SFI No. 21.3)

9.1 **Joint Finance Arrangements**

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation.

See overlap with Standing Financial Instruction No. 21.3.

SECTION C - SCHEME OF RESERVATION AND DELEGATION

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
NA	THE BOARD	***Regulations and Control*** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 5.2 5. Approve a scheme of delegation of powers from the Board to committees**.** 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		Executive's attention in accordance with SO 5.6. 16. Discipline members of the Board or employees who are in breach of statutory requirements or SOs. 17. Approve the establishment of a subsidiary company and the associated articles of association and operating framework
NA	THE BOARD	**Appointments/ Dismissal** 1. Appoint the Vice Chair of the Board. 2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2). 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders). 6. Approve proposals of the Remuneration Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration Committee.
NA	THE BOARD	***Strategy, Plans and Budgets*** 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment. 5. Approve budgets. 6. Approve annually Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a 3 year period or the period of the contract if longer. 11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		12. Approve individual compensation payments. 13. Approve proposals for action on litigation against or on behalf of the Trust. Review use of NHSLA risk pooling schemes (LPST/CNST/RPST).
	THE BOARD	**Policy Determination** 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. Policies so adopted shall be listed and held by the ~~Company Secretary~~Trust Secretary
	THE BOARD	**Audit** 1 Receipt of the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 2 Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
NA	THE BOARD	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for funds held on trust.
NA	THE BOARD	**Monitoring** 1. Receipt of such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board. 3. Receive reports from DoF on financial performance. 4. Receive reports from CE on performance matters by exception.

DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 11.1.1	AUDIT COMMITTEE	The Committee will act in accordance with the Audit Committee Handbook, and: 1. Advise the Board on internal and external audit services; 2. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; 3. The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. 4. The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. 5 Monitor compliance with Standing Orders and Standing Financial Instructions; 6 Review schedules of losses and compensations and making recommendations to the Board. 7 Review the annual financial statements prior to submission to the Board. A full list of responsibilities can be viewed in the Terms of reference for this committee which are appended to this document
SFI 20.1.2	REMUNERATION AND TERMS OF SERVICE COMMITTEE (REMUNERATION COMMITTEE)	The Committee will: 1. Advise the Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees including: 2. All aspects of salary (including any performance-related elements/bonuses); 3. Provisions for other benefits, including pensions and cars; 4. Arrangements for termination of employment and other contractual terms; 5. Make recommendations to the Board on the remuneration and terms of service of executive directors and senior employees to ensure they are fairly rewarded for their individual contribution to the Trust -

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff; 6. Proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate advise on and oversee appropriate contractual arrangements for such staff; 7. The Committee shall report in writing to the Board the basis for its recommendations. 8. Approve the Remuneration Framework for its subsidiaries. A full list of responsibilities can be viewed in the Terms of reference for this committee which are appended to this document
	QUALITY AND SAFETY COMMITTEE	The purpose of the Quality and Safety Committee (QSC) will be to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, research governance, information governance, health & safety, patient and public safety, compliance with CQC regulation and some workforce issues such as organisational culture and education and talent management. The Committee will be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the Trust's Clinical Strategy 2019-2024 and Quality Strategy. Please note the Trust's Audit Committee will ensure the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk and the Finance, Performance and Workforce Committee will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances QSC will provide scrutiny. ~~The purpose of the Quality and Safety Committee will be to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, research governance, information governance, health & safety, patient and public safety, organisational culture and OD and compliance with CQC regulation. The Committee will also be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the strategic objectives and quality.~~

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		A full list of responsibilities can be viewed in the Terms of reference for the committee which are appended to this document
	FINANCE AND PERFORMANCE COMMITTEE	The purpose of the Finance, Performance and Workforce Committee is to provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and workforce objectives which contribute to the delivery of the Trust Strategy. Through this work, the Committee will play a key role in ensuring the sustainability of the Trust. The Committee's work will include: • maintaining an overview of the development and maintenance of the Trust's medium and long term financial strategy; • providing scrutiny of operational performance; • monitoring elements of the Trust's people strategy, particularly in relation to resourcing and key controls; • maintaining oversight of the development and implementation of the Trust's digital strategy; • to monitor the creation and operation of the Trust's estates strategy; • overseeing risk management for the duties of the Committee. The Committee shall be kept informed of any developments relating to the Hertfordshire and West Essex Sustainability and Transformation Partnership that may impact on the work of the 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 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
	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.~~ 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.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		A full list of responsibilities can be viewed in the Terms of reference for the committee
	CHARITY TRUSTEE COMMITTEE	The purpose of the Charity Trustee Committee is: • To ensure a robust strategy for delivery of the Charity aims and objectives • To champion the charity and its development, providing leadership both within the Trust and externally • To provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies This is a delegated duty carried out on behalf of the East and North Hertfordshire NHS Trust, which is the sole *Corporate Trustee* of the charity, East & North Herts Hospitals (registered charity no 1053338). A full list of responsibilities can be viewed in the Terms of reference for the committee
	AUDITOR PANEL	In line with the requirements of the Local Audit and Accountability Act 2014 the Trust has established an Auditor Panel to enable the Trust to meet its statutory duties by advising on the selection, appointment and removal of the External Auditors and on maintaining an independent relationship with them. The Auditor Panel will not be required to convene in 2017/18, but this will be reinstated when the contract requires review. The Terms of Reference are approved by the Trust Board and reviewed on a periodic basis. The committee is comprised of the Audit Committee Non-Executive Directors. A full list of responsibilities can be viewed in the Terms of reference for the committee.

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

REF	DELEGATED TO	DUTIES DELEGATED
1 & 5	**CHIEF EXECUTIVE & ~~COMPANY SECRETARY~~TRUST SECRETARY**	**Review scheme of delegation**
7	CHIEF EXECUTIVE (CE)	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
9	CE AND DIRECTOR OF FINANCE (DOF)	Ensure the accounts of the Trust are prepared under principles and in a format directed by the SofS. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
10	CHIEF EXECUTIVE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
12 & 13	CHIEF EXECUTIVE	*Ensure effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers:* • "have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
12	CHAIR	Implement requirements of corporate governance.
13	CHIEF EXECUTIVE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports

REF	DELEGATED TO	DUTIES DELEGATED
		from such bodies as the NHSI and the National Audit Office (NAO).
15	DoF	Operational responsibility for effective and sound financial management and information.
15	CHIEF EXECUTIVE	Primary duty to see that DoF discharges this function.
16	CHIEF EXECUTIVE	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
18	CE and DoF	Chief Executive, supported by Director of Finance, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
19	CHIEF EXECUTIVE	If CE considers the Board or Chair is doing something that might infringe probity or regularity, he/she should set this out in writing to the Chair and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary NHS England and the Department of Health.
21	CHIEF EXECUTIVE	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CE's responsibility for value for money, the CE should draw the relevant factors to the attention of the Board. If the outcome is that he/she is overruled it is normally sufficient to ensure that his/her advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CE should inform the NHSI and the DH. In such cases, and in those described in paragraph 24, the CE should as a member of the Board vote against the course of action rather than merely abstain from voting.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.1.7	BOARD	Approve procedure for declaration of hospitality and sponsorship.
1.3.1.8	BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
1.31.9 & 1.3.2.2	ALL BOARD MEMBERS	Subscribe to Code of Conduct, Trust Values and coaching culture.
1.3.2.4	BOARD	Board members share corporate responsibility for all decisions of the Board.
1.3.2.4	CHAIR AND NON EXECUTIVE/OFFICER MEMBERS	Chair and non-officer members are responsible for monitoring the executive management of the organisation and are responsible to the SofS for the discharge of those responsibilities.
1.3.2.4	BOARD	The Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
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	CHAIR	It is the Chair's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board; 7. advise the Secretary of State on the performance of Non-Executive Board members.
1.3.2.5	CHIEF EXECUTIVE	The Chief Executive is accountable to the Chair and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		Memorandum.
1.3.2.6	NON EXECUTIVE DIRECTORS	Non-Executive Directors are appointed by NHSI – Appointments to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
1.3.2.8	CHAIR AND DIRECTORS	Declaration of conflict of interests.
1.3.2.9	BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SCHEME OF DELEGATION FROM STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	CHAIR	Final authority in interpretation of Standing Orders (SOs).
2.4	BOARD	Appointment of Vice Chair
3.1	CHAIR	Call meetings.
3.9	CHAIR	Chair all Board meetings and associated responsibilities.
3.10	CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIR	Having a second or casting vote
3.13	BOARD	Suspension of Standing Orders
3.13	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.14	BOARD	Variation or amendment of Standing Orders
4.1	BOARD	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Chief Executive.)
5.2	CHAIR & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	THE BOARD	Declare relevant and material interests.
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
7.4	ALL STAFF	Comply with national guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff" and Trust Values.
7.4	ALL	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
8.1/8.3	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
8.4	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	DIRECTOR OF FINANCE	Approval of all financial procedures.
10.1.4	DIRECTOR OF FINANCE	Advice on interpretation or application of SFIs.
10.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
10.2.3	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.3	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.4	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.5	DIRECTOR OF FINANCE	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and staff; e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
10.2.7	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.2.8	DIRECTOR OF FINANCE	All members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.
11.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
11.1.2	CHAIR	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 & 11.2.1	DIRECTOR OF FINANCE	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
11.2.1	DIRECTOR OF FINANCE	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
11.3	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with Public Sector Internal Audit Standards and best practice.
11.4	AUDIT COMMITTEE	Ensure cost-effective External Audit.
11.5	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
11.6	CHIEF EXECUTIVE	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
13.1.1	CHIEF EXECUTIVE	Compile and submit to the Board a delivery plan which takes into account financial targets and forecast limits of available resources. The plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
13.1.2 & 13.1.3	DIRECTOR OF FINANCE	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
13.1.4	BUDGET HOLDERS	All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
13.1.5	BUDGET HOLDERS	All budget holders will sign up to their allocated budgets at the commencement of each financial year.
13.1.6	DIRECTOR OF FINANCE	Ensure adequate training is delivered on an on going basis to budget holders.
13.3.1	CHIEF EXECUTIVE	Delegate budget to budget holders.
13.3.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
13.4.1	DIRECTOR OF FINANCE	Devise and maintain systems of budgetary control.
13.4.2	BUDGET HOLDERS	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment.
13.4.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the Annual Plan.
13.6.1	CHIEF EXECUTIVE	Submit monitoring returns
14.1	DIRECTOR OF FINANCE	Preparation of annual accounts and reports.
15.1	DIRECTOR OF FINANCE	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
16.	DIRECTOR OF FINANCE	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
16.2.3	ALL EMPLOYEES	Duty to inform DoF of money due from transactions which they initiate/deal with.
17.	CHIEF EXECUTIVE	Tendering and contract procedure.
17.5.3	CHIEF EXECUTIVE	Waive formal tendering procedures.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.5.3	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Board.
17.5.5	DIRECTOR OF FINANCE	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.
17.6.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders received.
17.6.3	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations despatched.
17.6.4	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Where one tender is received will assess for value for money and fair price.
17.6.6	CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.6.8	CHIEF EXECUTIVE	Will appoint a manager to maintain a list of approved firms.
17.6.9	CHIEF EXECUTIVE	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
17.7.2	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
17.7.4	CHIEF EXECUTIVE or DIRECTOR OF FINANCE	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.10	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
17.10	BOARD	All PFI proposals must be agreed by the Board.
17.11	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
17.12	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		employment, regarding staff, agency staff or temporary staff service contracts.
17.15	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
17.15.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
18.1.1	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
18.3	CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA
20.1.1	BOARD	Establish a Remuneration & Terms of Service Committee
20.1.2	REMUNERATION COMMITTEE	Advise the Board on and make recommendations on the remuneration and terms of service of the CE, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
20.1.3	REMUNERATION COMMITTEE	Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.
20.1.4	BOARD	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
20.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
20.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.4.1 and 20.4.2	DIRECTOR OF FINANCE	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 10.4.2).
20.4.3	NOMINATED MANAGERS*	Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time.
20.4.4	DIRECTOR OF FINANCE	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
20.5	NOMINATED MANAGER*	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
21.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. Authorised signatory list is maintained by the finance Department and available on request
21.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
21.2.1	REQUISITIONER*	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
21.2.2	DIRECTOR OF FINANCE	Shall be responsible for the prompt payment of accounts and claims.
21.2.3	DIRECTOR OF FINANCE	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
21.2.4	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
21.2.4	DIRECTOR OF FINANCE	Approve proposed prepayment arrangements.
21.2.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform DoF if problems are encountered).
21.2.5	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
21.2.6	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
21.2.7	CHIEF EXECUTIVE DIRECTOR OF FINANCE	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
21.3	DIRECTOR OF FINANCE	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
22.1.1	DIRECTOR OF FINANCE	The DoF will advise the Board on the Trust's ability to pay dividend on PDC and report, periodically, concerning the PDC debt and all loans and overdrafts.
22.1.1	BOARD	Will approve the Trust's plans for applications for short-term or longer-term borrowings and loans
22.1.2	BOARD	Approve a list of employees authorised to make applications and sign loan documentation on behalf of the Trust. (This must include the CE and DoF.)

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
22.1.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
22.1.4	CHIEF EXECUTIVE OR DIRECTOR OF FINANCE	Be on an authorising panel comprising at least one other member for loan and borrowing application and documentation submission..
22.2.2	DIRECTOR OF FINANCE	Will advise the Board on investments and report, periodically, on performance of same.
22.2.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions on the operation of investments held.
23	DIRECTOR OF FINANCE	Ensure that Board members are aware of the Financial Framework and ensure compliance
24.1.1 & 2	CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.
24.1.2	DIRECTOR OF FINANCE	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
24.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
24.1.4	DIRECTOR OF FINANCE	Assess the requirement for the operation of the construction industry taxation deduction scheme.
24.1.5	DIRECTOR OF FINANCE	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
24.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
24.1.7	DIRECTOR OF FINANCE	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
24.2.1	DIRECTOR OF FINANCE	Demonstrate that the use of private finance represents value for money and genuinely transfers

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		significant risk to the private sector.
24.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.
24.3.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from DoF).
24.3.5	DIRECTOR OF FINANCE	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
24.3.8	DIRECTOR OF FINANCE	Calculate and pay capital charges in accordance with Department of Health requirements.
24.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
24.4.2	DIRECTOR OF FINANCE	Approval of fixed asset control procedures.
24.4.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
25.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
25.2	DIRECTOR OF FINANCE	Responsible for systems of control over stores and receipt of goods.
25.2	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks
25.2	DESIGNATED ESTATES OFFICER	Responsible for control of stocks of fuel oil and coal.
25.2	NOMINATED OFFICERS*	Security arrangements and custody of keys
25.2	DIRECTOR OF FINANCE	Set out procedures and systems to regulate the stores.
25.2	DIRECTOR OF FINANCE	Agree stocktaking arrangements.
25.2	DIRECTOR OF FINANCE	Approve alternative arrangements where a complete system of stores control is not justified.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
25.2	DIRECTOR OF FINANCE	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
25.2	NOMINATED OFFICERS*	Operate system for slow moving and obsolete stock, and report to DoF evidence of significant overstocking.
25.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supply Chain.
26.1.1	DIRECTOR OF FINANCE	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
26.2.1	DIRECTOR OF FINANCE	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
26.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and DoF.
26.2.2	DIRECTOR OF FINANCE	Where a criminal offence is suspected, DoF must inform the police if theft or arson is involved. In cases of fraud and corruption DoF must inform the relevant LCFS, ~~and NHS Protect Regional Team~~ and NHS Counter Fraud Authority as required by NHS Counter Fraud Standards for Providers. ~~in line with SoS directions.~~
26.2.2	DIRECTOR OF FINANCE	Notify NHS Counter Fraud Authority ~~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

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		organisation assurances of adequacy must be obtained from them prior to implementation.
27.1.3	~~COMPANY SECRETARY~~TRUST SECRETARY	Shall ensure that a Freedom of Information Scheme is published and maintained.
27.2.1	RELEVANT OFFICERS	Send proposals for general computer systems to DoF
27.3	DIRECTOR OF FINANCE	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
27.4	DIRECTOR OF FINANCE	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
27.5	DIRECTOR OF FINANCE	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) DoF and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
28.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
28.3	DIRECTOR OF FINANCE	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
28.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
29.1	DIRECTOR OF FINANCE	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
30	~~COMPANY SECRETARY~~TRUST	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	SECRETARY	staff
32	CHIEF EXECUTIVE	Retention of document procedures in accordance with HSC 1999/053.
33.1	CHIEF EXECUTIVE	Risk management programme.
33.1	BOARD	Approve and monitor risk management programme.
33.2	BOARD	Decide whether the Trust will use the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
33.4	DIRECTOR OF FINANCE	Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
33.4	DIRECTOR OF FINANCE	Ensure documented procedures cover management of claims and payments below the deductible.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

SECTION D - STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

10.1 General

10.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust. Detailed delegated limits are outlined in Appendix 1 of this document.

10.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

10.1.5 **The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

10.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

10.2 Responsibilities and delegation

10.2.1 **The Trust Board**

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

10.2.2 The ~~Company secretary~~Trust Secretary holds a record of circumstances that the Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. All other powers have been delegated to such other committees as the Trust has established.

10.2.3 **The Chief Executive and Director of Finance**

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

10.2.4 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.5 **The Director of Finance**

The Director of Finance is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

10.2.6 **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.7 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

10.2.8 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.

11. AUDIT

11.1 Audit Committee

11.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2018), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

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

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

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

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

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

11.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health. (To the Director of Finance in the first instance.)

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

11.2 Director of Finance

11.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud 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 Chair and Chief Executive of the Trust.

11.3.4 The audit manager shall be accountable to the Audit Committee though the Head of Internal Audit and shall report to the Director of Finance for the operational delivery. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the audit manager. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every three years.

11.4 External Audit

11.4.1 The External Auditor is appointed following a selection and appointment process overseen by the 'Auditor Panel'. The Audit Committee will be responsible for the effectiveness of the external audit function and will receive reports from the external audit partner. The contract will be reviewed at least every three years. If there are issues with the external audit, these should be raised with the external auditor in the first place. If the removal of the external auditor is considered, the 'Auditor Panel' will need to be convened and a recommendation made to the Board.

11.5 Fraud 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.~~The Local Counter Fraud Specialist shall report to the Director of Finance and shall work with staff in NHS Counter Fraud Authority and equivalents and in accordance with the Standards for NHS Counter Fraud Standards for Providers and any other relevant guidance.

11.5.4 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

11.6 Security Management

11.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

11.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

12. RESOURCE LIMIT CONTROL

The Chief Executive as accountable officer and Director of Finance as accounting officer are responsible for controls that ensure the Trust operates within resource limits set by the Department of Health or NHSI.

13. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

13.1 Preparation and Approval of Plans and Budgets

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

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

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

13.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Plan

(b) accord with workload and manpower plans;

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

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

(e) identify potential risks.

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

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

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

13.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

13.2 Budgetary Delegation

13.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

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

13.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

13.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

13.3 Budgetary Control and Reporting

13.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) Movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

13.3.2 Each Budget Holder is responsible for ensuring that:

(a) Value for money is obtained from the use of resources, ensuring that these are used to obtain economy and effectiveness for the Trust

(b) Resources are not spent unnecessarily even if the appropriate budget exists

(c) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(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.

13.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Trust's plans and a balanced budget.

13.4 Capital Expenditure

13.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 24).

13.5 Monitoring Returns

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

14. ANNUAL ACCOUNTS AND REPORTS

14.1 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and generally accepted accounting practice;

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

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

14.2 The Trust's annual accounts must be audited by the appointed external auditor. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

14.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Manual for Accounts.

15. BANK AND GOVERNMENT BANKING SERVICE (GBS) ACCOUNTS

15.1 General

15.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements, developing a cash and treasury management policy and for advising the Trust on the provision of banking services and operation of accounts. This may include operating through a shared business service. It will take into account guidance/ Directions issued from time to time by the Department of Health. In line with 'Cash Management in the NHS' Trusts should minimize the use of commercial bank accounts and consider using GBS accounts for all banking services.

15.1.2 The Board shall approve the banking arrangements.

15.2 Bank and GBS Accounts

15.2.1 The Director of Finance is responsible for:

(a) bank accounts and Office of the Paymaster General (GBS) accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where prior arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

(e) monitoring compliance with DH guidance on the level of cleared funds.

15.3 Banking Procedures

15.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

(c) the use of shared business service.

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

15.4 Tendering and Review

15.4.1 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

15.4.2 Competitive tenders should be considered at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

16. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

16.1 Income Systems

16.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

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

16.2 Fees and Charges

16.2.1 The Trust shall comply with Department of Health tariffs in charging for activity that it has provided and follow the Department of Health's advice in the "Costing" Manual in setting prices for other NHS service agreements.

16.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship

income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

16.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

16.2.4 The Director of Finance will put in place such systems and processes necessary to ensure that income due from transactions is recorded and accounted for in a timely and effective way.

16.3 Debt Recovery

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

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

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

16.4 Security of Cash, Cheques and other Negotiable Instruments

16.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

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

16.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

16.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

16.5 2003 Money Laundering Regulations

Under no circumstances will the Trust accept cash payments in excess of 15,000 Euros (converted to sterling at the prevailing rate at the time) in respect of any single transaction. Any attempt to effect payment above this amount should be immediately notified to the Director of Finance.

17. TENDERING AND CONTRACTING PROCEDURE

17.1 General

The Trust shall use Hertfordshire NHS Procurement for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented. If the Trust does not use Hertfordshire NHS Procurement the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

17.2 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

17.3 EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

17.4 Reverse eAuctions

Reverse eAuctions will be conducted in accordance with Trust policy and procedures in place for the control of all tendering activity carried out through this process.

17.5 Capital Investment and other Department of Health Guidance

The Trust shall comply with the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts, including delegated limits, issued by NHSI as far as is practicable and "Estate code" in respect of capital investment and estate and property transactions. In the case of management consultancy contracts and temporary staffing contracts the Trust shall comply as far as is practicable with the requirements of NHSI..

17.6 Formal Competitive Tendering

17.6.1 **General Applicability**

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

17.6.2 **Health Care Services**

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 18 and No. 19.

17.6.3 **Exceptions and instances where formal tendering need not be applied**

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the amounts set out in the procurement scheme of delegation. (see appendix to this report)

(b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No. 25;

(d) where a national or regional arrangement is in place: CCS Crown Commercial Service framework agreements, collaborative procurement hub contracts, NHS Supply Chain framework and local agreements arranged through Hertfordshire NHS Procurement.

Formal tendering procedures **may be waived** in the following circumstances:

(e) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(f) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(g) where specialist expertise is required and is available from only one source;

(h) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(i) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(j) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record endorsed in accordance with the Trust's procurement scheme of delegation.

17.6.4 **Building and Engineering Construction Works**

Competitive Tendering cannot be waived for building and engineering construction works and maintenance unless permitted under Department of Health Estates and Facilities guidance which may require specific Department of Health Approval. ~~(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;~~ electronically on the e- Procurement portal Bravo Solutions

~~(b)~~(a)

~~(c)~~(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 electronically.

The date and time of receipt of each tender shall be endorsed on the e-tendering System or endorsed on the unopened tender envelope/package.

17.7.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened ~~by two senior officers/managers designated by the Chief Executive and not from the originating department.~~ Electronically via the e-Tendering portal Bravo

(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 electronically 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~~ Bravo/JA electronic tendering system. This shall enable: The required levels of calls for competition; a supplier information database; a process to request for prequalification information; evaluation of expressions of interest & prequalification questionnaires; creation of quotation/tender documents; invitation to tender; receipt of tenders; opening procedures evaluation award; contract management; and archiving of tender documentation

~~(ii)~~ Tenders will be returned to an „electronic safe and locked until the due date for the receipt of bids from invited suppliers. As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened ~~by the Head of Procurement~~Director of Procurement ~~(Hertfordshire NHS Procurement) as the Chief Executive nominated representative. Should the Head of Procurement~~Director 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)~~(ii)

~~(iv)~~(iii) The ~~Head of Procurement~~Director of Procurement (Hertfordshire NHS Procurement) as guardian for the ~~Due North~~Bravo system is responsible for ensuring all tenders are treated as confidential and retained for inspection. The system provides a register of: the name of all firms or individuals invited to tender; the names of firms or individuals from which tenders have been received; the date the tenders were opened; and the price shown on each tender.

(iv) There is generally no discretion to receive tenders after the due date. In exceptional circumstances the ~~Head of Procurement~~Director of Procurement (Hertfordshire NHS Procurement) may request the Chief Executive approve the inclusion of a late tender. The request will include an explanation of the exceptional circumstance and assurance that the tender process has not been compromised.

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

Where only one tender is sought and/or received, the Chief Executive and Finance Director shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

Any discussions with a tenderer which are deemed necessary to clarify technical aspects of the tender before the award of a contract will not disqualify the tender.

The most economically advantageous tender shall be accepted as determined by the tender evaluation criteria set by the tender project team at the start of the tender process.

No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Executive.

The use of these procedures must demonstrate that the award of the contract was not in excess of the going market rate / price current at the time the contract was awarded; and that best value for money was achieved.

(vi) The ~~Head of Procurement~~Director of Procurement (Hertfordshire NHS Procurement) as the Chief Executive nominated officer responsible for tendering will report to the Trust Board on an exceptional circumstance basis as required by the Chief Executive.

17.7.8 **Tender reports to the Trust Board**

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

17.8 Quotations: Competitive and non-competitive

17.8.1 **General Position on quotations**

Quotations are required where formal tendering procedures are not adopted because the intended expenditure or income does not exceed the amounts set out in the scheme of delegation.

17.8.2 **Quotations**

(i) Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(ii) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(iii) All quotations should be treated as confidential and should be retained for inspection.

(iv) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

17.8.3 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

17.9 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the staff as set out in the Trusts' procurement scheme of delegation (as per appendix 1 to this report).

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

17.10 Private Finance for capital procurement (see overlap with SFI No. 24)

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

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

(b) Where the sum exceeds delegated limits, a business case must be referred to NHSI for approval or treated as per current guidelines.

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

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

17.11 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including NHSI Capital Investment guidance and Estate code;

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

17.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

17.13 Healthcare Services Agreements (see overlap with SFI No. 18)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

17.14 Disposals (See overlap with SFI No. 26)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the procurement policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

17.15 In-house Services

17.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

17.15.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a procurement officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £1m, a non-officer member should be a member of the evaluation team.

17.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

17.15.4 The evaluation team shall make recommendations to the Board.

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

17.16 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 29)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

18. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 17.13)

18.1 Service Level Agreements (SLAs)

18.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within future plans and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

18.2 Involving Partners and jointly managing risk

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

18.3 Commissioning

NHS England has published NHS Funding and Resource 2017-2019, as an annex to Next steps on the NHS Five Year Forward View, its Business Plan for 2018/19. This sets out the commissioning upon which the Government's major reform agenda will be carried forward in line with the National Health Service Act 2006 as amended by the Health and Social Care Act 2012. The latest guidance can be accessed on www.england.nhs.uk

18.4 Reports to Board on SLAs

The Chief Executive, as the Accountable Officer, will ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

19. THIS SECTION IS NOT APPLICABLE TO NHS TRUSTS

20. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

20.1 Remuneration and Terms of Service (see overlap with SO No. 4)

20.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

20.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other officer members employed by the Trust and other senior employees including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of officer members of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members (and other senior employees);

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

(e) Agree the framework or broad policy for remuneration for Directors of the subsidiary

20.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

20.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

20.1.5 The Trust will pay allowances to the Chair and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health.

20.2 **Funded Establishment**

20.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

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

20.3 Staff Appointments

20.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive or delegated relevant Director;

(b) within the limit of their approved budget and funded establishment.

20.3.2 20.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

20.4 Processing Payroll

20.4.1 The Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) putting in place procedures for the authorisation of the overall payroll file

(d) making payment on agreed dates;

(e) agreeing method of payment.

20.4.2 The Director of Finance will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(I) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

20.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

20.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

20.5 Contracts of Employment

20.5.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

21. NON-PAY EXPENDITURE

21.1 Delegation of Authority

21.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers. Current delegated limits are shown as Appendix to this document.

21.1.2 The Chief Executive will set out:

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

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

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

21.1.4 Where the Trust has approved systems for obtaining goods and services, such as i-Procurement, Pharmacy systems or materials management systems, all officers and managers are required to use those systems. Contravention of systems must be supported by a waiver, which will be reported to the Audit Committee.

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

21.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust by using the Trust's approved systems. Except in areas that are exempt from the process (such as Pharmaceuticals), the advice of the Trust's procurement department (Hertfordshire NHS Procurement) shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

21.2.2 **System of Payment and Payment Verification**

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Board employees authorised to certify invoices.

(ii) A process of electronic certification.

(iii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iv) A process for prompt submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(v) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.4 below.

21.2.3 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

21.2.4 **Official orders**

Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

21.2.5 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

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

(d) with regard to the Bribery Act 2010 no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 6 and Managing Conflicts of Interest Policy and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff");

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

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

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

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

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

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

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

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

21.2.6 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

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

21.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act **shall** comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

22. EXTERNAL BORROWING

22.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

22.1.2 The Finance Director will maintain a list of employees (including specimens of their signatures) who are authorised to enact previously approved short-term borrowings on behalf of the Trust.

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

22.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health.

22.1.5 Any short-term borrowing must be with the authority of two members of an authorised signatory list. The Board must be made aware of all short-term borrowings at the next Board meeting.

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

22.2 INVESTMENTS

22.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

22.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

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

23. FINANCIAL FRAMEWORK

23.3.1 The Director of Finance should ensure that members of the Board are aware of the Financial Framework. The Trust's medium term and longer-term financial strategy, the planned sources of funding including any external borrowing and repayment plan.

24. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

24.1 Capital Investment

24.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges;

(d) shall ensure that there is consultation with commissioners regarding capital investment of a strategic nature, or which has a material affect on income streams

24.1.2 For every capital expenditure proposal (other than those described in 24.1.4 and 24.1.5 below) the Chief Executive shall ensure:

(a) that a business case (in line with the guidance issued by NHSI on Capital Investment for NHS Trusts is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

24.1.3 Capital Review Control Group, (reports to the FPC through the Director of Finance report)), meets on a monthly basis and performs the following functions:

(a) Considers applications for capital investment from Divisions and Corporate Directorates against risk of non-investment;

(b) Draws up a proposed capital programme for the next year for discussion and agreement at the Divisional Executive Committee;

(c) Sets the capital budgets following approval by DEC;

(d) monitors progress of capital projects against budget;

(e) reports to the FPC on progress made on capital projects after each meeting

(f) liaises with Divisions and Project Sponsors to aid the progression and management of capital schemes

(g) monitors the procurement of donated assets valued over £100k and reports to the Charity Trustee Committee

(h) review all capital risks at the Trust

(i) ensures that the Capital Resource Limit (CRL is achieved at the Trust)

(j) to review and verify assets held at the Trust ensuring that the Trust Asset register is accurate.

24.1.4 Business cases presented to the Business Development Committee and Capital Review Group should consider sources of funding including purchase, private or other finance and lease funding. The Trust uses ~~Leaseguard~~ Lifecycle 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~~ Lifecycle recommendations will be reviewed by the user department and by Finance, but lease agreements can only be authorised in accordance with the Trust's Authorised Signatories for Lease Documentation.

24.1.5 On an annual basis the Deputy Chief Operating Officer, Director of Estates and Head of IT collate capital requests from the Clinical Divisions which are considered at a special Divisional Operations Committee meeting, together with requirements from their own areas. The applications are considered for inclusion on the Annual Capital Programme. A schedule of approved bids will be prepared for review at the Capital Review Group. Bids are to be made on a standard template which considers the following:

(a) the mitigation of clinical or operational risk

(b) the revenue consequences associated with the capital spend

(c) EBME advice

(d) infection control advice

(e) implications for clinical workload

(f) discussions with commissioners if the implications for workload materially impact on income streams

(g) any IT resource requirements or Information Governance considerations.

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

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

24.1.8 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

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

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

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

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

(a) specific authority to commit expenditure;

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

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

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

24.1.12 –The Business Development Committee shall review all business cases at each of the three key stages – Strategic Outline Case, the Outline Business Case, the Full Business Case. This is to support business decisions are taken which support the strategic objectives, support the development and sustainability of quality services; are in line with the Trust's core strategies; are based on the best available intelligence; are fully impact assessed; are made within the context of the developing market and the existing and potential partnerships which could be developed to best exploit this market.

The Business Development Committee will report its recommendations to the Executive/Divisional Executive committee and the business cases recommended for approval will be submitted to the Committee with the right level of authorisation as defined in the terms of reference.

24.1.13 The Finance and Performance 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

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

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

24.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

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

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.

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

24.3 Asset Registers

24.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

24.3.2 The minimum data set to be held within the Trust's register shall be sufficient to identify, locate and value assets appropriately.

24.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) Notification of project completion by the relevant project manager who is responsible for ensuring properly authorized and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties.

(b) Purchase and installation of equipment.

(c) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(d) lease agreements in respect of assets held under a finance lease and capitalised.

24.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate) that are the responsibility of the relevant budget-holder.

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

24.3.6 The value of each asset shall be measured at its fair value in accordance with Trust's accounting policies.

24.3.7 The value of each asset shall be depreciated using methods and rates as specified to reflect the consumption of the assets economic useful life in accordance with the Trust's accounting policies.

24.3.8 The Director of Finance of the Trust shall calculate and pay a dividend based the required return on assets in accordance with department of Health accounting policies, currently set at 3.5%.

24.4 Security of Assets

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

24.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

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

24.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

24.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss, including through theft, damage or obsolescence, of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses. A summary of such losses will be reported to the Audit Committee at least twice a year.

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

25. STORES AND RECEIPT OF GOODS

25.1 General position

25.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

25.2 Control of Stores, Stocktaking, condemnations and disposal

25.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

25.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

25.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

25.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

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

25.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance the value of all losses and any evidence of significant overstocking and of any negligence or malpractice (see also overlap with

SFI No. 25 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

25.3 Goods supplied by NHS Supply Chain

25.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note. Any discrepancies should be reported to NHS Supply Chain. The Director of Finance shall satisfy himself that the goods have been received before accepting the recharge.

26. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

26.1 Disposals and Condemnations

26.1.1 **Procedures**

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

26.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

26.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

26.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

26.2 Losses and Special Payments

26.2.1 **Procedures**

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

26.2.2 Any employee or officer discovering or suspecting a loss of any kind must refer to the Trust's Anti-Fraud and Bribery Policy and either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud 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.~~ who will decide, in consultation with the Director of Finance, whether notification to NHS Counter Fraud Authority is appropriate. The External Auditor will be notified of all frauds.

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.

Formatted: Indent: Left: 0 cm, Hanging: 1.52 cm

26.2.10 Approval of requests for write off of bad debts will be subject to the detailed Scheme of Delegation in the Appendix to this document. All bad debts written off must be reported to the next meeting of the Losses and Special Payments Committee, which must report to the Audit Committee on a twice-yearly basis.

26.2.11 Under delegated powers the Losses and Special Payments Committee can approve payments to patients, staff and members of the public in respect of approved personal property claims up to the delegated limit without recourse to the Director of Finance. These claims will form part of the twice-year report to Audit Committee.

27. INFORMATION TECHNOLOGY

27.1 Responsibilities and duties of the Director of Finance

27.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

27.1.2 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

27.1.3 The ~~Company Secretary~~Trust Secretary shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

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

27.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

27.3 Contracts for Computer Services with other health bodies or outside agencies

The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

27.4 Risk Assessment

The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

27.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

28. PATIENTS' PROPERTY

28.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

28.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; ***(notices are subject to sensitivity guidance)***
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

28.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

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

28.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

28.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

28.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

29. FUNDS HELD ON TRUST

29.1 Corporate Trustee

(1) Standing Order No. 2.8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SFI 4.9.3 that defines the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

29.2 Accountability to Charity Commission and Secretary of State for Health

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

(2) The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

29.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 17.16).

(2) The over-riding principle is that the integrity of the Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

30. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The ~~Company Secretary~~Trust Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff; Managing Conflicts of Interest Policy. This policy follows the national guidance on Managing Conflicts of Interest in the NHS 2017and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

31. PAYMENTS TO INDEPENDENT CONTRACTORS

Not applicable to NHS Trusts.

32. RETENTION OF RECORDS

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

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

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

33. RISK MANAGEMENT AND INSURANCE

33.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;
e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement on the effectiveness of Internal Control within the Annual Report and Accounts as required by current Department of Health guidance.

33.2 Insurance: Risk Pooling Schemes administered by NHS Resolution

The Board shall decide if the Trust will insure through the risk pooling schemes administered by NHS Resolution or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

33.3 Insurance arrangements with commercial insurers

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

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

(2) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Director of Finance should consult the Department of Health.

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

(1) Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Appendix 1

Detailed Procurement Process

Introduction

In deciding what goods and services to procure, the Trust must be able to demonstrate that it has obtained Value for Money and compliant with Public Procurement regulations. In all cases of doubt in the procedure to be adopted, The Trust's Procurement service provider should be consulted. The procedure below outlines the process to be followed only and does not cover who would be responsible for signing any resultant Purchase Order – these levels are covered in Appendix 2.

Exceptions from competitive purchasing procedures

In certain instances, there are national NHS contracts in force which mean that goods and services need to be sourced from a particular supplier. In other instances, procurement hubs have undertaken competitive tendering processes and due diligence for a generic range of goods and services. A list of approved suppliers under a framework has been developed by these organisations that the Trust can choose to use without the need for a further round of competitive process. The Trust's Procurement service provider can provide details of national contracts and approved supplier frameworks.

If, for any reason, the Trust opts not to go an approved framework, it will need to demonstrate that there has been fair competition. If, in the case of overwhelming reason, that there has not been a competitive process, a Waiver to Standing Financial Instructions must be completed and signed by the appropriate signatory before the contract is awarded. These waivers are reported to the Finance Performance Committee by the ~~Head of Procurement~~Director of Procurement.

Competitive procedures

Where a framework or national contract has not been used, the outline procedures below must be followed

Contract or purchase value below £10,000 (exc.VAT)

There is no formal requirement to undertake a competitive process. However, the overall requirement is to deliver the best value for the Trust. This may not necessarily mean that the cheapest product needs to be bought, but price against other factors such as longevity or fit with other products needs to be considered. This decision-making process is likely to be needed to be evidenced to authorising managers.

Contract or purchase between £10,001 and £50,000 (exc.VAT)

At least three competitive written quotations will need to be obtained. As above, the selection may not be the cheapest, but there should be an evidenced evaluation of value for money to the Trust. The selection will need to be endorsed by the ~~Head of Procurement~~Director of Procurement as well as the authorising manager. A Quotations Register is maintained by Procurement.

Contract or purchase between £50,001 and the OJEU limit (currently £~~106,047~~ £118,113) exc VAT

There will need to be a formal tendering exercise undertaken, managed by The Trust's Procurement service provider. Any waiver to this process will need to be endorsed by the ~~Head of Procurement~~Director of Procurement and approved by the Director of Finance (in his absence the Deputy Director of Finance).

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

Contract or purchase over OJEU limit (currently ~~£106,047~~£118,113)

An OJEU-compliant tendering process will need to be undertaken. There can be no waiver to this process. For tender values over £1m, a Board member will need to ~~be present~~ give approval.

Appendix 2

Detailed Limits of Delegation Policy

Introduction - Authorisation Limits

Where Directors, managers and other staff are authorising transactions on the Trust's behalf, the presumption is that they are doing so within the remit of their position as defined below, and within agreed budgets. Anyone operating outside these parameters will be considered as acting without due authority and may be subject to formal disciplinary procedures.

The processes below do not replace the Procurement process which requires obtaining competitive quotations and tenders, except in defined circumstances. Once the competitive process has been completed, any associated order is subject to the approval process below.

1. **Trust Service Level Agreements**

The Trust is commissioned to provide both clinical services and non-clinical services to other NHS and non-NHS organisations. It also receives services from other organisations. Provision or receipt of services over a period needs to be supported by a formal Service Level Agreement. New services should be subject to Board, DEC or Exec approval through the Business Case process, and the Service Level Agreements for the extension of existing agreements need to be reviewed by the Senior Contract Manager within Finance before approval.

The values below are based over the lifetime of the contract, as the responsible officer will be committing the Trust to the terms of that contract. Circumvention of the approval process, by splitting the contract into smaller units e.g. monthly payments, will be viewed as a disciplinary issue.

Type	Amount	Responsible Officer	Current Limit
Patient Activity Service Level Agreements with Commissioners	Over £50,000,001pa	Chief Executive and Director of Finance	To be nominated by the Chief Executive, ~~but no formal limits set in the existing limits of delegation~~limits Unchanged
	Between £10,000,001 and £50,000,000	Director of Finance	
	Up to £10,000,000pa	Chief Operating Officer and Assistant Director of Finance (Financial Planning)	
Agreements for the provision of non-patient services to other organisations *	Over £5,000,001pa	Chief Executive and Director of Finance	
	Between £1,000,001pa and £5,000,000	Director of Finance and appropriate Executive Director i.e Chief Operating Officer for Estates or Chief People Officer for HR SLAs	
	Between £10,001pa and £1,000,000	Deputy Director of Finance and Corporate Lead e.g. Estates, Finance, HR	
	Up to £10,000pa	Assistant or Associate Director of Finance and Corporate Lead e.g. Estates, Finance, HR	
Expenditure Service Level Agreements with other NHS bodies (Clinical)	Over £50,000,001pa	Chief Executive	
	Between £10,000,001 and £50,000,000	Director of Finance	
	Between £10,001pa and £1,000,000	Deputy Director of Finance and Divisional Director	
	Up to £10,000pa	Assistant or Associate Director of Finance and Divisional Director	
Expenditure Service Level Agreements with other NHS bodies (Non-Clinical)*	Over £5,000,000pa	Chief Executive and appropriate Executive Director i.e Chief Operating Officer for Estates or Chief People Officer for HR SLAs	
	Between £1,000,001pa and £5,000,000	Director of Finance and appropriate Executive Director i.e Chief Operating Officer for Estates or Chief People	

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

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

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

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

The amount of order value being considered for approval will be based on the agreed contractual value or, where the contract is over a period of years, the lifetime of the contract.

Please Note: The values below do not replace those for competitive quotations or waivers.

Type	Amount	Authorised Officer	Current Approver
Contracts ~~and consequent Purchase Orders on first agreement of contract~~for the provision of goods and services	Over £1,000,001	Subject to Board approval	~~Head of Procurement~~Director of Procurement~~,~~ ~~Director of Finance, Director of Operations or Director of Estates (depending on type of supply) – Over £113,057 and up to any limit~~No change to approver limits
	Over £750,001 and up to £1,000,000	Chief Executive	
	Over £250,001 and up to £750,000	Director of Finance	
	Over £100,001 and up to £250,000	Other Executive Director	
	Over £50,001 and up to £100,000	Deputy Director of Finance	~~General Manager or Supply Chain Manager~~Unchanged~~d~~
	Over £10,001and up to £50,000	Divisional Director/Divisional Chair/Assistant Director of Corporate area	~~Deputy General Manager or equivalent e.g Matron, Fin Mgr~~Unchanged
	Up to £10,000	General Manager, Divisional Nursing Services Manager, Head of Service	~~Up to £5,000 – Budget Holder or nominated Deputy~~Unchanged

Pharmaceuticals	Any value	Director of Finance, Chief Operating Officer	Unchanged
	Up to £50,000	Head Pharmacist	
~~Subsequent~~ Catalogue or Non-Catalogue Orders, including Estates and Catering, once contracts have been agreed and non purchase order invoices	Over £750,001	~~Director of Finance~~Chief Executive or as delegated to Director of Finance	Director of Finance – over £1,000,001 Other Executive Directors £500,001 and up to £1,000,000
	Over £250,001 and up to £750,000	Director of Finance	
	Over £~~500,001~~100,001 and up to £~~1,000,000~~250,000	Other Executive Director	
	Over £50,001 and up to £100,000	Deputy Director of finance	~~General Manager or Supply Chain Manager up to £106,047, otherwise above~~Over £50,001 and up to £500,000
	Over £~~5~~10,001 and up to £50,000	Divisional Director/Assistant Director of Corporate area	~~Deputy General Manager or equivalent e.g Matron, Fin Mgr~~over £5,001 and up to £50,000
	Over £5,000 and up to £10,000	General Manager, Divisional Nursing Service~~s~~ Manager, Head of Service	Up to £5,000
	Over £1,001 and up to £5,000	Departmental head / Budget Manager (Band 8 and above)	New limit
	Up to £1,000	Budget Manager (Band 7)	New limit
Pharmaceuticals	Any value	Director of Finance, Director of Operations	Unchanged
	Up to £50,000	Head Pharmacist	Unchanged

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

Type	Amount	Authorised Officer	Current Approver
All payment types below	Over £250,000	Director of Finance	Unchanged~~Any Director (over £106,047)~~
Utilities (Phones, Electric, Gas, Water, Waste Collections)	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged~~General Manager up to £106,047~~
	Up to £50,000	Head of relevant area (IT, Estates)	Unchanged~~Deputy General manager~~
Rates	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged~~General Manager up to £106,047~~
	Up to £50,000	Director of Estates	Unchanged~~Deputy General manager~~
Lease car invoices	Over £5,001 and up to £250,000	Deputy Director of Finance	Unchanged~~General Manager up to £106,047~~
	Up to £5,000	Financial Controller	Unchanged~~Deputy General manager~~
Computershare invoices (nursery vouchers)	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged~~General Manager up to £106,047~~
	Over £5,001 and Up to £50,000	Financial Controller	Up to £50,000
	Up to £5,000	Deputy Financial Controller	No limit

3. **Other Payments**

Payment Type	Amount	Responsible Officer	Current approver
All payment types below	Over £250,000	Director of Finance	Unchanged~~Any Director (over £106,047)~~
	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged~~General Manager up to £113,057~~
NHS Supply Chain invoices for 'top up' of materials management	Up to £50,000	Approved by Financial Controller/Deputy Financial Controller	Unchanged~~Deputy General manager~~
Payroll Payments	Main Trust Payroll	Director of Finance or Deputy in his/her absence	Unchanged~~No current delegated limits documented~~
	Supplementary Payroll	Up to £30,000 Deputy Director of Finance or Financial Controller, otherwise Director of	

		Finance	
	ENH Pharma Payroll	Pharma Director of Finance, Deputy Director of Finance or Financial Controller up to £200,000, otherwise Trust Director of Finance	
	Garden House Hospice Payroll	As per Supplementary Payroll above	
Payroll deduction payovers, such as Union subs, Court Orders, Tax/NI and Pension Scheme payments	If these reconciled to approved payrolls as above	Deputy Director of Finance or Financial Controller	
'Faster' Payments , based on approved invoices or payroll requests	Up to £50,000	Financial Controller or Deputy Financial Controller	

4. **Capital Expenditure**

The Capital Review Group will recommend the capital programme for each financial year to Exec, who will approve this programme. Any capital expenditure outside this programme will need to be presented in a formal bid to CRG to ensure that all Estates, Equipment and IT implications have been considered before it can be presented to the Exec meeting for approval. This includes all potential revenue schemes which have a capital implication.

Once the schemes have been approved, approval limits for orders placed will follow the revenue limits above outlined in Section2.

5. **Payroll and Other Contractual Payments connected with Employment**

Budget managers have delegated authority to approve pay, subject to the payments being within their funded establishment. However, any payments outside normal contractual terms and conditions, not reserved for approval by the Remuneration Committee, can only be made with the approval of the Director of Finance.

Type	Amount	Authorised Officer	Current Approver
Timesheets, recruitment forms, change forms	Any within budgetary limits confirmations	Line manager	Unchanged~~No change~~
Contractual payments on termination e.g. lieu of notice or redundancy	Over £10,001	Director of Finance	Unchanged
	Up to £10,000	Chief People Officer	Unchanged
Removal Expenses	Over £8,001	Director of Finance	Unchanged
	Up to £8,000	Chief People Officer or Director of Workforce	Unchanged

6. **Non-Contractual Payments connected with Employment**

Type	Amount	Authorised Officer	Current Approver
Extra contractual payments on termination (discretionary)	Any	None – these require approval by HM Treasury	Unchanged
Payments in connection with Employment Disputes e.g. Employment Tribunals	Over £50,001	Trust Board (or Chair and Chief Executive on behalf of the Board)	Unchanged
	Between £10,001 and £50,000	Chief People Officer and Chief Executive	Unchanged
	Up to £10,000	Chief People Officer or Director of Workforce	Unchanged

7. **Credit Note Requests**

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

Invoice Type	Amount	Responsible Officer	Current approver
SLA/NCA Income from Commissioners	Up to £1,000	Assistant Director of Finance (Income and Contracts)	Unchanged ~~No current documented limits~~
	Over £1,001 to £50,000	Assistant Director of Finance (Financial Planning) or Financial Controller	
	Over £5,001 and up to £500,000	Deputy Director of Finance	
	Over £500,001	Director of Finance	
Other Operating Income raised through Management Accounts	Up to £5,000	Deputy Financial Controller	
	Over £5,001 and up to £50,000	Assistant Director of Finance or Financial Controller	
	Over £50,001 and up to £500,000	Deputy Director of Finance	
	Over £500,001	Director of Finance	
Private Patient/Overseas Visitors Invoices	Up to £5,000	Deputy Financial Controller	
	Over £5,001 and up to £50,000	Financial Controller or Assistant Director of Finance	
	Over £50,001 and up to £500,000	Deputy Director of Finance	
	Over £500,001	Director of Finance	

8. **Losses and Special Payments**

Category	Amount	Responsible Officer	Current approver
Bad debts Write-Off (must always have dual signatories)	Up to £1,000	Financial Controller plus One Assistant Director of Finance	Unchanged~~Financial Controller £3,000 (per invoice) Deputy Director of Finance £15,000 (per invoice) Director Finance – Any invoice above £15,000 One signature only required~~
	Over £1,001 and up to £5,000	Financial Controller or Assistant Director of Finance plus Deputy Director of Finance	
	Over £5,001 and up to £100,000	Financial Controller, Assistant or Deputy Director of Finance plus Director of Finance	
	Over £100,001 and up to £250,000	Chief Executive and Director of Finance	
	Over £250,001	Board	
Fraud/Theft	All values	To be reported to Audit Committee	Unchanged~~No change~~
Other Losses	To be approved through the Losses and Special Payments Committee in line with the Losses and Special Payments Policy. A summary is to be provided to Audit Committee twice yearly.		Unchanged~~No change~~

9. **Charitable Funds**

Before Charitable Funds income agreements (such as grant applications, acceptance of legacies and significant donations) and expenditure can be approved, it is expected that the Trust Business Case and governance processes have been adhered to. This will include confirmation of the support of divisions, identification of potential revenue issues for the Trust, compliance with Trust strategy and so on. In case of doubt, the Head of Engagement should be consulted.

Income and expenditure over the lifetime of the scheme or project should be considered

Category	Amount	Responsible Officer	Current approver
All income and expenditure agreements	Up to £5,000	Approved fundholder	Unchanged~~No change~~
	Over £5,001	Charitable Trustees Committee	Unchanged~~No change~~

10. **ENH Pharma**

Approval limits will be set by the ENH Pharma Board, under its own Scheme of Delegation. However, the Trust expects that the governance processes will take into account the underlying principles contained within its Standing Orders and Standing Financial Instructions

East and North Hertfordshire NHS Trust

Agenda Item: 13

TRUST BOARD – PUBLIC SESSION – 6 NOVEMBER 2019
Board Assurance Framework 2019 20 Update

Purpose of report and executive summary (250 words max):
To present the latest version of the Board Assurance Framework 2019 20 (appendix 1) for consideration.

Since the previous meeting the Board should note that:

- There have not been any changes to the risk scores in month
- **Risks 4 (Capital) and Risk 11 (Estates and Facilities compliance)** remain at a 20. Mitigations and actions in place. See updates in appendix.
- **Risk 1, performance (capacity and demand)** was presented to the Audit Committee for a deep dive at the committee on 28 October 2019. They were assured on the controls, assurances and mitigations in place and noted that the FPC was undertaking regular reviews of areas of performance including winter planning and capacity and demand.
- **Risk 7 (governance)**. The risk has been updated to reflect the very recent receipt of 3 HSE improvement notices – Violence and aggression, Moving and Handling and sharps. The notices were reviewed and discussed in full at QSC and Audit Committee. The action plan is currently under development and will be presented through the Quailty and Safety Committee to Board in December / January. Compliance will be monitored through the Health and safety committee, QSC and Audit Committee. The deadline to respond to the HSE with the Trust action plan is January 2020.
  The outcome of the CQC and use of resources reports are anticipated in November 2019 for factual accuracy and will inform the December reviews.
- **Risk 12 – MVCC –** FPC will be considering this risk in the context of the strategic change at its next meeting.

- The strategic risks presented on the new framework for 2019/20 with the revised strategic risks as approved by the Board in May 2019. This will enable the Board and its committees to have clearer visibility of the causes and effects of the risk and greater alignment of the controls, assurances and actions; thus supporting scrutiny and challenge and strengthening effective review and management of our risks. This work will continue through 2019/20.
- A review of the risk with each lead director concluded in August and monthly reviews have continued. The purpose of this review will be to test the controls, assurances, KPIs and actions are all identified and documented and to agree the target risks associated timeline. A cross reference exercise of all the annual operational objectives to the BAF will be undertaken in conjunction with this and assurance maps are being developed to underpin each risk.
- The Risk Manager and Associate Director of Corporate Governance will undertake a review of the BAF against the recently approved risk appetite statements and develop a short 'risk appetite at a glance' reference guide to support future BAF reviews. This has been delayed to Q3/4 due to staff sickness in Q2.

Action required: For discussion

Previously considered by:
The Board Assurance Framework is considered at each FPC,QSC & Public Board.

Director:	**Presented by:**	**Author:**
Director of Strategy	**Associate Director of Corporate Governance**	**Associate Director of Corporate Governance**

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒

Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	X☐

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

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

Risk Scoring Guide

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

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

Trust risk scoring matrix and grading

Likelihood

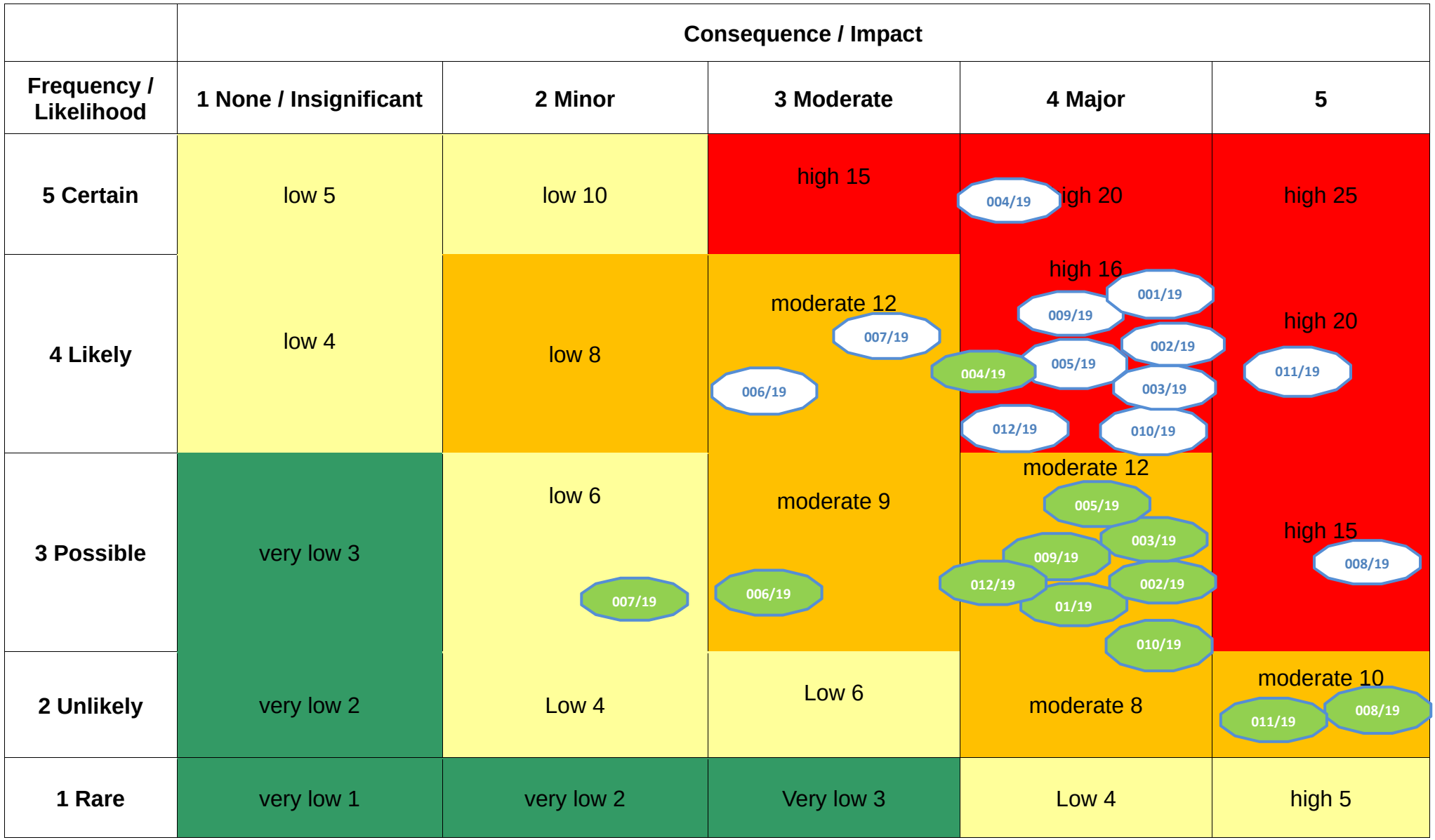
Impact	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
Death / Catastrophe 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
None /Insignificant 1	1	2	3	4	5

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

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description	Lead Executive	Committee	Current Risk	Last Month	3 months ago	6 months ago	Target Score	Date added (all reviewed in October 19)
001/19	There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT and the A&E 4-hour standards	Chief Operating Officer	FPC	16	16	16	20	12	01-03-18
002/19	There is a risk that the trust is unable to recruit and retain sufficient supply of staff with the right skills to meet the demand for services	Director of Nursing /Medical Director/CPO	FPC	16	16	16	16	12	01-03-18
003/19	There is a risk that the Trust is unable to achieve financial sustainability to support the delivery of the Operational Plan and 5year clinical strategy	Director of Finance	FPC	16	25	16	20	12	01-04-19
004/19 (was 6)	There is a risk that there is insufficient capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments	Director of Finance	FPC	20	20	20	16	16	01-03-18
005/19	There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy	Director of Finance/ COO	FPC	16	16	20	20	12	01-04-17
006/19 (was 10)	There is a risk that the STP does not work effectively to redesign and implement new models of care, which impacts on the hospital's ability to manage demand for services	Director of Strategy	FPC	12	12	12	12	9	01-03-18
007/19	There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives	Chief Executive	Board of Directors	12	12	12	12	12	01-03-18
008/19 (was 11)	There is a risk that the Trust is not always able to consistently embed of a safety culture and evidence of continuous quality improvement and patient experience	Director of Nursing /Medical Director	QSC	15	15	15	20	10	01-03-18
009/19	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered, impacting on the Trust's ability to deliver the required improvements and transformation	Chief People Officer	FPC & QSC	16	16	16	16	12	01-03-18
010/19 was 013/19	There is a risk that the Trust is adversely affected by the United Kingdom's departure from the European Union, particularly in the event of no deal being secured.	Director of Strategy	FPC	16	16	12	n/a	12	19-09-18
011/19(was 014/19	There is a risk that the Trust's Estates and Facilities compliance arrangements including fire management are inadequate leading to harm or loss of life.	Director of Strategy	QSC	20	20	20	N/A	10	22/01/19
012/19	There is a risk that the Trust is not able to secure the long-term future of the MVCC	Director of Strategy	FPC	16	16	12	12	12	01-03-18

Board Assurance Framework Heat Map –September 2019



008/18 Existing risk score

011/18 Target risk score

Movement from previous month

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**Pathways: To develop pathways across care boundaries, where this delivers best patient care invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff**				**Ease of Use: To redesign and**
Strategic Objective:	**Improve and sustain delivery of operational performance**		**Source of Risk:**	Strategic Objective IPR	**BAF REF No:** 001/19
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the trust is not able to provide timely and effective patient care through the delivery of compliant and sustained performance standards, specifically in relation to the 4 hour, RTT and cancer.**			**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner** Chief Operating Officer
			Risk Review Date:	Oct-19	**Lead Committee:** FPC

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Increases / changes to capacity and demand . v) Impact of specialist commissioning review and resultant outcome for MVCC on staff retension and recruitment, impacting on effectiveness of the cancer team. ii) leadership and capacity challenges iii) conflicting priorities iv) Inconsistency in application of pathways/ processes iv) Impact of tax issue on Consultants willingness to undertake WLIs.	i) Limited ability to respond to changes in capacity and demand impacting on service delivery ii) Adverse impact on sustaining delivery of core standards iii) impact on patient safety, experience and outcomes iv) increased regulatory scrutiny v) reputation	**Inherent Risk** (Without controls):	4	5	20	
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• ED Patient flow improvement steering group/ Delivery Board • Three times weekly work stream meetings including Red to Green • Weekly ED Team/COO meeting • Length of Stay consultant led reviews • Daily system telephone conference • Weekly access meeting chaired by COO • Three tier cancer tracking meeting; Divisional PRMs • Trust representation on A&E delivery Board/ Cancer Board/ STP • Integrated Care Team engagement • Additional management resource secured to support delivery of cancer timed pathway programme - CIMBIO reports and monitoring - speciality and consultant level monitoring of access plans when completed and failsafe TCI waiting list office reconciliation. Linked to training to improve compliance - Programme Boards - OPD Board, Theatre Board, Length of Stay review panel - ED breach review and vailidation and SoP - re launch of winter planning group July 2019 Comprehensive D&C work undertaken by speciality teams supported by in house D&C team and external IST team. Aim is to identify capacity gaps which will be addressed through a series of actions to include job plan review, efficiecy improvement e.g. reduction in DNA rate; increase utilisation in theatres and where required funding for substantive resources.	• A&E Delivery Board (L1) • System Resilience Group (L2) • Reports to FPC and Board of Directors (L3) • NHSI PRM(L3) • Cancer Board (L2) • Daily and weekly ED sit-rep reporting • Monthly breach validation audits • Monthly Performance Deep Dives considered by FPC – e.g. ED in June 2018 and rolling programme • NHSI – Deep dive – cancer recovery plan (L3) • IPR Report to Feb and March 19 FPC meeting 6 and 5 out of the 8 cancer standards, RTT performance above national average • Closure of escalation winter ward • Internal Audit – Performance Framework report - reasonable assurance March 19) Internal audits scheduled for 2019/20 include - clinical capacity and utilisation; emergency department;theatre productivity Regulator oversight - weekly detailed performace call	Internal Audit – Performance Framework report - reasonable assurance March 19) Validated demand and capacity by tumor site modelling by NHSI - led to increase investment in urology.		
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**			
Bed Occupancy and LOS reductions not being delivered consistently across specialities. Sufficient surgical capacity to deliver cancer treatments within required timeframes Demand and capacity modelling for all high impact tumour sites complete.	• Accountability Framework arrangements • Impact of local Hospitals on Trust activity • Demand and capacity profiling for T&O, Pain , oral surgery to inform future business planning Review and response to Market analysis	Green	Effective control is in place and Board satisfied that appropriate assurances are available		
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient		

Access to funding streams from the cancer alliance allocation - availabilty of capital to support developments	- Access to social care support at weekends - 7 day working linked to job planning	Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Implementation of patient flow work programme	Chief Operating Officer	on going	sameday emergency care programme in progress	In progress
ii) Implementation of agreed improvement plans for cancer, RTT and diagnostics	Chief Operating Officer	on going	Concer proformance improving. 62 day pathway in track for delivery and sustained by October 2019. RTT- focus on delivery of reductin of 52 wk breaches	In progress
iii) Review capacity and demand modelling outcomes and determine associated actions to support delivery of the clinical strategy	Chief Operating Officer	on going	T&O, Pain and oral surgery identifed as the next areas for capacity and demand modelling to inform future business planning.	In progress
iv) Continue to review and strengthen operational and governance structures	Chief Operating Officer	on going		In progress
v) To agree and develop further integrated pathways of care with our commissioners	Chief Operating Officer	on going	Postive planned careand urgent/emergency care transformation day in November with CCG. Review of Same Day Emergency Care and Frality model in progress.	In progress
Summary Narrative:				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**People:** **To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce**				
Strategic Objective:	**Develop, support, engage and transform our workforce to provide quality services**	**Source of Risk:**	Operational Plan, Clinical Strategy, IPR	**BAF REF No:**	002/19
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the trust is unable to recruit and retain sufficient supply of staff with the right skills to meet the demand for services		**Risk Open Date:**	1.3.18	**Executive Lead/ Risk Owner**	**Chief People Officer**
		Risk Review Date:	Oct-19	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) National shortage of nurses and doctors ii) Limited strategic workforce planning iii) Availability of training	i) Impact on staff morale ii) Impact on quality and safety iii) adverse financial impact	**Inherent Risk** (Without controls):	4	5	20	⇕ ⇔
		Residual/ Current Risk:	4	4	16	⇔
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Monthly nursing and midwifery workforce steering group • Monthly nursing look ahead – heat map / agreed agency levels • Site safety huddles to review real time staffing and capacity • Quarterly establishment reviews – skill mix, acuity and dependency • Safe care – 3 times daily staffing reviews • University of Hertfordshire recruitment • Rotation of band 5 nurses to aid retention • NHSI Wave 2 retention programme • Eroster • Scheduled regular monthly updates of staffing data to NHSP, to ensure staffing lists as accurate as they can be. • Retention Strategy • Arrangements in place to support our employees who are EU nationals re Brexit-related settled status applications.	• Report to QSC on medical staffing (L2) • Report to Board of Directors via QSC on safer staffing (L2) • Workforce report to FPC (L2) • Safer Staffing reports (L2) • NHS Professionals continuously recruiting to nursing and midwifery band 2 and band 5 roles. • Reviewing and trialling alternative shift patterns to attract staff; rapid response • Development of joint recruitment and attraction strategy with STP. • Launch of retention strategy focusing on band 5 nurses and band 2 CSWs. • Local retention targets and plans - Internal audits shceduled for 2019/20 - consultant job planning, safer staffing,			
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**			
• 40,000 nurses short across the country • Camb/London recruitment/weighting • Capacity to balance quality, money and operational pressure. • Staff leavers higher than expected in some areas • Specific targeted recruitment required for some specialities / specialists • Deanery plans reduction in rotation of medical trainees to DGHs	• Data consistency and quality • Improved retention rates • Recruitment in specialty / hard to recruit areas 5 yr Workforce strategy to support the new 5 yr clinical strategy	Green	Effective control is in place and Board satisfied that appropriate assurances are available		
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient		
		Red	Effective controls may not be in place and assurances are not available to the Board.		
Action Plan to Address Gaps					

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Develop and implement workforce strategy to support the trust new 5 yr clinical strategy	Chief People Officer	September 19 (TBC)		In progress
ii) Implement overseas recruitment plans for 2019/20	Head of Recruitment	Jun-19	international and domestic nursing and medical recruitment was agreed in May 2019. An agreed target for international recruitment was confirmed along with an increased effort to recruit domestic nurses using a variety of tools and incentives to aid recruitment and retention. This work has already commenced and a progress review is due in July 2019. 153 new starters joined the Trust in April 2019 and the vacancy rate as at end of March 2019 was 7.2%. 71 new starters joined the Trust in May 2019 and the vacancy rate as at end of May 2019 was 7%. Divisions have been set targets for their workforce per staff group and this willbe monitored at the weekly Improving Financial Delivery meetings. A formal progress review was taken to Executives in September 2019 with a prediction that, based on known activity and trajectories, the Trust is likely to meet its recruitment targets for 2019/2020. 141 starters joined the Trust in August 2019 and the vacancy rate as at end of August 2019 was 6.94%.	In progress
iii) • Resourcing Strategy to be launched in 2019/20 setting out the Trust's approach to recruitment and retention.	Chief People Officer	TBC	Draft workforce redeployment policy by Head of HR expected by end 2019.	In progress
iv) Review of Trusts Communication strategy to support recruitment and retention	Communication Team / Head of HR			
Summary Narrative:				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:					
Strategic Objective:	**Meet our financial obligations** **Seek innovative STP-wide solutions to address clinically and financially unsustainable services**	**Source of Risk:**	- Operating Plan - Use of Resources	**BAF REF No:**	003/19
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the Trust is unable to achieve financial sustainability to support the devlivery of the Operational Plan and 5 year Clinical Strategy.**		**Risk Open Date:**	01/04/2018	**Executive Lead/ Risk Owner**	**Director of Finance**
		Risk Review Date:	Oct-19	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Demand and capacity planning ii) Shortfall in CIP delivery iii) Good financial management is not embedded at all levels iv) Data quailty not optimised	i) Impact on cash flow ii) CIP programme not delivered iii) Financial plan not delivered iv) unable to invest in service development v) increased CCG test and challenge and regulatory scrutiny	**Inherent Risk** (Without controls):	4	5	20	
		Residual/ Current Risk:	4	4	16	⟷
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrics aligned to IPR**
• Qlikview SLA income and activity application developed and in place (weekly and monthly) • Monthly SLA income reports to FPC / DEC and Divisions • Divisional Performance & Activity meetings (PAM) in place to review deliver • Monthly CQUIN meetings to review progress in place • Contract monitoring meetings in place with all commissioners • Key monitoring metrics reflected in new divisional PRM dashboards • CIP Work programme and workstreams - Exec review weekly • Fully established PMO function in place supporting delivery • Finance and project training programmes in place for budet holders to access • Weekly Improving Finance Delivery IFD meetings in place • £3m Contingency fund building across YTD • Coding and Data Quality Strategy reviewed at Audit Committee	• Independent reviews of coding and counting practice undertaken in 17/18 (L3) • Actions plans to address findings in place and reviewed at PAM (L1) • Regular Data quality and Clinical Coding updates to PAM and AC (L2) • Weekly OP drumbeat session re- introduced in January 2019 • CIP tracker in place to monitor delivery achievement (L1) • Monthly Finace Reports to FPC, Board and Divisions (L1) • Monthly cash reporting to FPC / Trust Board and NHSI(L2) • Monthly Accountability Framework ARMs including finance (L1) • Internal Audit – Financial Planning Process L3 +) • Monthly Financial Assurance Meetings & PRM with NHSI (L1) • FPC Deep Dives into remedial performance issues eg. Theatres	• Internal Audit - key financial control, CIP governance, performance framework 2018/19. • Summary of review of budget risks and controls into FPC May and June 2019		• Delivery of Control Total Target (Trust Level) • I&E delivery against agreed 19/20 budget plans • Agency Staffing within NHSI notified ceiling • Cash balances within agreed EFL target
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		

• Potential challenge from commissioners in respect of volume of planned work undertaken • Comprehensive bed model and associated demand & capacity modelling • Implementation of Same Day Admission pathway change and the understanding of financial impacts • Requirement to support discharge summary remedial activity impacting upon DQ team capacity to respond to CCG challenges and queries • Pace of CIP delivery achievement • Pace of Theatre and Outpatient transformation delivery • Slippage in IFD mitigations • Temporary staffing control environment in respect of medical and nursing staffing	• Limited demand and capacity modelling • delivery of CIP schemes • delivery of activity levels • Gaps in business skill sets across divisions eg. rostering, waiting list management, budgetary management	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Monitor delivery of CIP programme and support in the development of remedial action plans where required, specifically in relation to Theatres and Temp staffing control (Medical and Nursing)	PMO Director	on going	CIP portfiolio value at 16.97M (113% of 2019/20 target. Additional improvement work continues. Significant scruitny of each scheme and monitoring of delivery.	In progress
ii) Monitor delivery of divisional operational plans through IFD meetings , PAM and Accounabilty review meetings	Director of Finance / CPO	on going	In place and IFD reviewed to support delivery and reproting to ARMs.	In progress
iii) Implementaion of the outcomes of the capacity and demand modeling	Director of Finance / COO	on going	Delivery tracked through PAM Meetings	In progress
iv) Continue to develop BI and support divisions / directorates using effectively	Director of Finance	on going	Ongoing embedding and further development of dahsboards and data sets development	In progress
v) Prepare for use of resources assessment	Executive	Aug-19	Awaiting outcome of assessment - anticipated November 2019	In progress
Summary Narrative:				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**Quality: To deliver high quality, compassionate services, consistently across all our sites Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**				
Strategic Objective:	**Design, develop, launch and embed the Quality Strategy Seek innovative STP-wide solutions to address clinically and financially unsustainable services Complete stabilisation and commence optimisation of Lorenzo and make our services easier to use**	**Source of Risk:**	Business Plan, Clinical Strategy	**BAF REF No:**	004/19
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that there is insufficient capital resources to address all high/medium estates backlog maintenance, investment for medical equipment and service development		**Risk Open Date:**	01.03.18	**Executive Lead/ Risk Owner**	**Director of Finance**
		Risk Review Date:	Oct-19	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of available capital resources to enable investment ii) Trust in current deficit position iii) Requirement to repay capital loan debts	i) Poor patient experience ii) Patient Safety iii) limited ability to invest in IMT, equipment and services develoments iv) limited innovation	**Inherent Risk** (Without controls):	4	5	25	⇔
		Residual/ Current Risk:	4	5	20	
		Target Risk:	4	4	16	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Six Facet survey undertaken in 17/18 • Capital review Group meets monthly • Prioritising areas for limited capital spend through capital plan • Fire policy and risk assessments in place • Major incident plan • Mandatory training • Equipment Maintenance contracts • Monitoring of risks and incidents	• Report on Fire Safety to Executive Committee (L2) • Monthly Capital Review Group (CRG meetings) feeding into FPC and Exec Committe (L1) • Report on Fire and Backlog maintenance to RAQC(L2) • Reports to Health and Safety Committee (L2) • Capital plan report to FPC (L2) • Annual Fire report (L3) • PLACE reviews (L3) • Reports to Quality and Safety Committee • Deep dive review of the risks and mitigations (December 2018) • new Monthly Fire Safety Committee established March (includes other sites)			• Capital Expenditure within agreed CRL

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
• Not fully compliant with all Fire regulations and design • 1960s buildings difficult to maintain • No formalised equipment replacement plan or long term capital requirement linked through to LTFM • Estates and facilities monitoring structures and reporting	• Availability of capital	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps				
Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete

i) Estates strategy to support the five-year trust strategy	Director of Estates and Facilities	September (TBC)	Awaiting new Director to lead on this	Not yet started
ii) Develop capital equipment replacement plan	TBC	TBC		
iii) Develop programme for Charity to suppport with fundraising	Deputy Direoctr of Finance / Head of Charities	on going	ongoing	
iv) Agree capital investment for 2019/20 and monitor delivery	Executive	May 2019 and ongoing	Captial programme approved through CRG and Ececutive committee in June2019. CRG will monitor delivery	In progress
iv) Review other sources of fundung / opporunities for investment	Director of Finance / Porject leads	on going	Bid to NHSI for review including additional funding for fire.	in progress
Summary Narrative:				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**Ease of Use:** To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff services that is financially and clinically sustainable in the long term **Sustainability:** To provide a portfolio of				
Strategic Objective:	**Complete stabilisation and commence optimisation of Lorenzo and make our services easier to use**	**Source of Risk:**	Project	**BAF REF No:**	005/2019
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy		**Risk Open Date:**	Feb-18	**Executive Lead/ Risk Owner**	**Director of Finance / Chief Operating Officer**
		Risk Review Date:	Oct-19	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Poor staff engagement in new systems and processes ii) Not all staff received the required training and support iii) Not all existing trust systems interface between systems iv) Lack of funding natioanlly or locally to complete the programme	i) Unable to deliver financial performance ii) Unable to deliver target levels of patient activity iii) Unable to meet contractual digital objectives (local, national, licience) iv) adverse impact on performance reporting	**Inherent Risk** (Without controls):	4	5	20	
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**iii)**	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
i) Digital programme 2019 iii) Internal monitoring of programme implementation through - FPC and Board , Staff training and communication - generic and targeted Clinical review group, operational and governance oversight group/clinical approval group reporting into Digital Programme Board	• Monitoring of key safety and quality indicators through PRM's (L2) • Reports to Executive Committee, FPC and Board (L2) • Weekly Executive monitoring of implementation plans . data quality internal audit scheduled for 2019/20 - CIMBIO reporting and monitoring linking to training and support plans . First clinical approval group (CAG) July 2019	Closed post stabilisation workstreams - access plans, ereferals, hardware - supported by external review group with NHSI/D		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
i)Consistancy and compliance in the application of new processes on the systems ii) Availabilty of capital to deliver priorities - year 2 and beyond.		Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

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

i) Complete rollout of the new discharge summary across all lorenzo wards	Michael Chilvers, MD / Anne Powell	End of May 2019	Wave 5 and 6 implementaiton plan for remaining areas 14.05.19-31.05.19. Completed and adherance to process being monitored. Project completed. Now being embedded into practice.	Completed.
ii) Develop Ditigal Strategy and associated Digital Programme	Mark Stanton, CIO	End of June 2019	In progress - report to FPC in June 2019. Rescheduled for September 2019 (on agenda)	In progress,
iii) Review and implementation of revised Digital Strategy Programme Governance	Mark Stanton, CIO	End of May 2019	Proposed governance structure to be presented to FPC in May 2019 . New structures implemented in July 2019	Completed.
iv) Implement the quick wins initiative programme	Mark Stanton, CIO	Ongoing	Commencing late May as a 6 wk programmeto deliver a number of outstanding pipeline requests. Developing as a tool for new IT governance and linking to larger digital programme deliveries. Report to FPC in June 19.	Completed.
iv) Continue vaildation of records to data to ensure adhererance to the new processes	Des Lane, Associate Director of Information	On going	On going and deteriorating patient digital workstream commenced.	In progress
Summary Narrative:				

Risk carried forward from 2018/19. Stablisation to be completed by 31 May 2019. New digital strategy, associated digital programme and revised governance structure are in progress. Funding for EPMA confirmed from NHS Digital for implemetation by February 2020.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**Pathways: To develop pathways across care boundaries, where this delivers best patient care and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff**				**Ease of Use: To redesign**
Strategic Objective:	**Play a leading role in the Sustainability and Transformation Partnership (STP) development of the Integrated Care System / Alliance Seek innovative STP-wide solutions to address clinically and financially unsustainable services**	**Source of Risk:**		**BAF REF No:**	006/19 (previously 010/18)
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the STP does not work effectively to redesign and implement new models of care, which impacts on the hospital's ability to manage demand for services**		**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner**	**Director of Strategy**
		Risk Review Date:	Oct-19	**Lead Committee:**	**FPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Long term system leadership ii) Clinical and operational leadership and capacity iii) Capacity in primary and community services to deliver change iv) Current legal framework not designed to fully support ICP/S's v) Limited internal capacity and capability to engage	i) System does not deliver intergrated care pathways ii) Demand for acute services exceeds plan iii) Delay development integrated care for ENH iv) Inability to implement agreed models due to contractual, financial and legal barriers v) risk that external stakeholders are able to progress at a quicker pace than our capacity to be fully involved and contribute to the pathway design	**Inherent Risk** (Without controls):	3	5	15	
		Residual/ Current Risk:	3	4	12	
		Target Risk:	3	3	9	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Participation in STP work streams including Planned care, urgent and emergency care, frailty and cancer • STP CEO bi-weekly meeting Representation at STP Chairs meeting • Vascular Hub project with West Herts and PAH • Cancer work stream of STP (chaired by Director of Strategy) and representing STP Cancer Alliance • Model Hospital redesign work • Integrated discharge team • External partner to support development of STP • New independent chair in place to drive progress. (Ten year plan published sets out expectations for ICSs) System Transformation days set up for ENH (COO). STP identified as Accelerator site for national support. ENH Chief Executives' Oversight Meeting	• Reports to Board regarding progress on STP(L2) • Regular oversight by NHSI and NHSE (L2) • Monthly A&E delivery Board (L2) • Transformation Board of the CCG(L2) • Reports of Model Hospital work streams to Programme Board (L2) • NHSE Deep-dive into cancer work stream (L3) - Review of trust worksteam leads and internal governacne structure April 2019 Regular updates considered at Executive Committee	• NHSE Deep-dive into cancer work stream (L3) Executive Team and Trust Board consideration of ICP development (Sept 2019). Agreement to joint ICP winter planning for 2019 and QIPP planning for 20/21.		
	Gaps in Assurance: Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
• Scope for accelerated development of STP and its governance arrangements • Need for external resource to develop STP to ICS	Oversight of the workstreams at local level and at sub Board level	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Ensure effective involvement with all workstreams and monthly reporting to Strategic Programme Board and Executive Committee	Director of Strategy	on going	Monthly reportss provided to Strategic programme Board and Executive. STP Pathology Procurement in progress with the service specification. Executive and clinical engagement. Strategic Programme Board to be replaced by Strategy Committee from Nov 2019 with remit including ICP and ICS development.	In progress
ii) Monitor and actively participate in STP programme to develop ICS	Chief Executive and Chair	on going	Executive dsiucssion and Board update and dsicussion took place Sept 2019. Director of Strategy one of two ENH ICP representatives on the STP ICS/ICP Architecture Committee.	In progress
iii) Arrange Board development session on ICS - addressing contractual and legal risks and issue	Chair, Director of Strategy, Associate Director of Corporate Governance	schedule for 2019	In addition to above, the STP has arranged for workshops on ICS and ICP development with STP Board members in Nov and December 2019. Trust representatives being identified for these.	In progress
iv) Actively support and provide collaborative leadership to support the development of the ENH ICP	Chief Executive and Director of Strategy	on going	CEO joint lead with HCT CEO for the ENH ICP. Draft clinical priorities identified in discucssion with ICP partners and reflected in draftLong Term Plan. Executive Ttransition Group established to devise and support the transition to shadow ICP from April 2020. Trust has worked collabortively with ENHCCG, HPFT, HCC and HCT to develop the first draft narrative of the ICP submission for the long term plan.	In progress
Summary Narrative:				

Sept 19: The Trust is actively working with emerging ICP partners to identify clinical priorities for pathway transformation and develop governance for the future ICP which will support a QI approach to transformation. There is a need to review and align current ENH system transformtion work and the organisational restructure to the emerging ICP clinical priororities in order to align resources to support optimal impact on population health management. This work is ongoing and progress is being overseen by the ENH CEOs' Group. This work is forwards facing and includes joint planning for winter with HCT. Emergency activity is currently above plan ehich suggests that the ICP needs to continue to identify and deliver more effective ways of effectivly mnaging emergency growth - this will be a priority area for collaborative working. Ocober 2019: CEOs' Group has agreed tp identify additional capacity to help drive the development of the ICP transition programme. Executive Directors' Group has been tasked with supporting development of the shadow ICP. Trust to review and refresh Year 2 of the clinical strategy in the contxt of emerging ICP vision and priorities.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term** **Quality: To deliver high quality, compassionate services, consistently across all our sites**				
Strategic Objective:	**Improve and sustain delivery of operational performance** **Design, develop, launch and embed the Quality Strategy** **Meet our financial obligations**	**Source of Risk:**	Strategic Objectives External reviews	**BAF REF No:**	**007/19**
Principal Risk Description: What could prevent the objective from being achieved? **There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives**		**Risk Open Date:**	01.03.2018	**Executive Lead/ Risk Owner**	**Chief Executive**
		Risk Review Date:	Oct-19	**Lead Committee:**	**Board**

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

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Monthly Board meeting/Board Development Session/ Board Committees • Annual Internal Audit Programme/ LCFS service and annual plan • Standing Financial Instructions and Standing Financial Orders • Each NED linked to a Division (from January 2018) • Commissioned external reviews • Review of external benchmarks including model hospital , CQC Insight– reports to FPC and RAQC (QSC) • Board Assurance Framework and monthly review • Performance Management Framework/Accountability Review meetings monthly • Integrated Performance Report reviewed month at Trust Board, FPC and QSC - Quailty dashboard / compliance dashboard CQC steering group and action plan 2019/20 action plan to deliver the Trust strategy -Stretegic programme board and trsut board monitoring	• Commissioned external reviews – PwC Governance Review September 2017 NHSI review of Board and its committees 2019 • Visibility of Corporate risks and BAF as Board Committees and Board (L2) • Internal Audits delivered against plan, outcomes report to Audit Committee • Annual review of SFI/SFOs (L3) • Annual review of board committee effectiveness and terms of reference (May-July) (L3) • PwC Governance review and action plan closed (included well led assessment) (L3) • Annual governance statement (L3) • Counter fraud annual assessment and plan (L3) • Annual self-assessment on licence conditions FT4 (L3) • CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3 -/+) • Use of resources report July 2018 – requires improvement (L3 _/+) • September 2018 Progress report on CQC actions and section 29a (L2 +) to CQC & Quality Improvement Board • Annual review of RAQC to Board (L2 +) • Internal Audit Report – Assurance and Risk Management (- reasonable assurance (L3) • Board development session on Risk and Risk Appetite, Feb 2019 • Internal Audit – Performance Framework report - reasonable assurance March 19) - Internal Audits 2019/20 scheduled for Data Quailty; Divisional Governance;	Internal Audit report - risk management , performance framework, IG 2019 NHSI Infection control review - green - June 2019 Review of progress with QTP workstreams with NHSI/CCG - June 2019. Internal Audit - Surgical division governance - reasonable assurnance - July 2019.		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
Effectiveness of goverancne structures at ward to Divisional level • Fully embedding Performance Management Framework/Accountability Framework • Implementation of Internal Audit Recommendations • NHSI Undertaking January 2019 / CQC section 29a warning - surgery and QEII UCC - HSE Improvement notices received on V&A, MSD and sharps in October 2019	• Embedded risk management - CRR and BAF • Embedding effective use of the Integrated performance report • Evidence of timely implementation of audit actions • Consistency in the effectiveness of the governance structure's at all levels • Capacity to ensure proactive approach to compliance and assurance • Oversight of GIRFT programme and other exteranl reviews and follow up - follow up investigations on V&A and Sharps incidents - MH equipment - review and replacement programme - specialist training	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Monitor delivery of Risk Management implementaion plan 2019/20 including risk appetite	Associate Director of Corporate Governance / Risk Manager	ongoing	Monthly reports to Board committees	In progress
ii) Review of well led compliance and implement recommendations from NHSI Board and Committee observations to strenghten Board governance	Associate Director of Corporate Governance	Sep-19	Board development session in April commenced review of well -led. Follow up session scheduled for June 2019. Continue to review workforce matters, and reviewing DEC/Executive Committees	In progress
iii) Complete recruiment into revised corporate and quailty and safety structures and substantive Executive Director posts	Associate Director of Corporate Governance / Director of Nursing	Jul-19	One current vacancy in corporate goverance team; DPO to be advertised in July. Final QI posts in process of recruitment	In progress
iv) Review and develop a 'business as usual' programme of compliance / quality and safety reviews	Associate Director of Corporate Governance / Director of Nursing	Oct-19	Review of self assessment frameworks and mock inspeciton paperwork in progress with current programme	In progress
v) Review implementation of Trust clinical strategy and enabling strategies	Director of Strategy		Reports to the Board and Board committees scheduled	In progress
vi) Review effectiveness of governance at a Divisional level	Associate Director of Corporate Governance	Jan-19	Internal Audit scheduled. ARM reflections. Internal audit of surgical division - reasonable assurance.	In progress
v) Implementation of project plan for CQC Inspection and Use of Resources Inspection	Associate Director of Corporate Governance / Director of Nursing	Aug-19	In progress with weekly reporting to Executive Committee. Inspections anticipated for July - Sept 19. CQC focus groups being promoted (3-5 July) . Inspections completed and awaiting draft reports and outcome	In progress
v) develop and implement action plan to address HSE findings and improvement notices	Associate Director of Corporate Governance	January 2020 - action plan to HSE	Action plan under development. Scheduled to present draft action plan to Executive Committee through to QSC in November. Trust partnership engaged. Action taken 23.10.19 to have a security officer in the ED 24/7 with immediate effect. Reviewing H&S structure to support a more proactive service across the Trust.	In progress
Summary Narrative:				

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2019-20

Strategic Aim:	**Quality: To deliver high quality, compassionate services, consistently across all our sites**				
Strategic Objective:	**Design, develop, launch and embed the Quality Strategy**	**Source of Risk:**	Strategic Objective CQC Inspection	**BAF REF No:**	008/19 (previously 011/18)
Principal Risk Decription: What could prevent the objective from being achieved?**There is a risk that the Trust is not always able to consistently embed of a safety culture and evidence of continuous quality improvement and patient experience**		**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner**	**Director of Nursing /Medical Director**
		Risk Review Date:	Oct-19	**Lead Committee:**	**QSC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of consistant approach to quality improvement ii)Limited staff engagement iii) Inconsistent ward to board governance structures and systems	i) Limited learning from incidents ii) Impact of patient safety / patient expereince iii) impact on reputation iv) increased regulatory scruitny	**Inherent Risk** (Without controls):	5	4	20	⇕ ⇔
		Residual/ Current Risk:	5	3	15	⇔
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Clinical effectiveness committee / Patient Safety Committee/ Patient Experience Committee • Quality Improvement Board • Accountability Framework • CQC Engagement meeting • Increased Director presence in clinical areas • SIs and Learning from death investigations • Monthly patient safety newsletter • Bi-weekly IPC improvement board • Strengthened TIPCC membership and ToRs • Quality and safety visits • Safety huddles • Policies and procedures • New Quality Manager posts in each division • Weekly review meetings of CQC improvement plans • Clinical Harm Review Panel (Weekly)	• Reports to QSC (L2) • Quality review meetings with CCG (L2) • Divisional Performance Meetings (L2) • Clinical effectiveness/ Patient Safety/Patient Experience Committee reports (L2) • Monitoring of new to follow up ratios through OPD steering group and access meetings(L2) • Peer Reviews (L3) • Audit Programme (internal and external) (L3) • Quality Transformation Programme reports and deep dives to QSC • CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3) • NHSI Infection control review December 2018 - green (L3) • Quality Dashboard / Compliance dashboard Internal Audit scheduled 2019/20 - QTP, deteriorating patient, 7 day services	NHSI Infection control review June 2019 - Green		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
• National guidance and GIRFT Gap analysis identifies areas for improvement • Consistency with procurement and engagement with clinicians • Patient safety team capacity • Gaps in compliance with IPC Hygiene Code leading to C-difficile outbreak in April 2018 and MRSA bacteraemia in May 2018 • Gap in compliance with CQC standards warning notice section 29A – Surgery Lister and UCC QEII	• Consistency in following care bundles • Implementation of action plans • Embedding of learning from SIs/Learning from Deaths • Data quality • Inconsistent audit and monitoring programme • Delivery against CQC improvement plan	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

#VALUE!

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Delivery of the QTP implementation programme against plan	Associate Director of Quailty Improvement	ongoing	Progress / deep dive reports to QSC	In progress
ii) Delivery and monitoring of CQC improvement plans for Surgery Lister and UCC QEII and other core pathways	Associate Director of Corporate Governance / Director of Nursing	Jul-19	Internal monitoirngand review continues each month. Awaiting outcome of the CQC inspection and section 29a (anticapated November 2019)	In progress
iii) Launch and implementation of the quailty strategy with communication plan	Director of Nursing / Medical Director	ongoing	Launched event held in May 2019, supported with the Trust conversation session in June 2019. first learning trust wide event held 21 June . Reporting cycle to QSC reviewed with schedluded deep dives.	In progress
iv)• Complete Gap analysis on GIRFT reports and develop and monitor action plans	Medical Director	ongoing		In progress
iv) Implement 7 day services plan	Medical Director	ongoing	Report to QSC June 2019. Steering group established.	In progress
				In progress
Summary Narrative:				

Board Annual Cycle 2019-20

A formal Trust Board meeting is held on alternate months with Board Development sessions held in the month in-between.

Items	*Apr 2019	May 2019	*Jun 2019	Jul 2019	Aug 2019	Sep 2019	*Oct 2018	Nov 2019	*Dec 2019	Jan 2020	*Feb 2020	Mar 2020
Standing Items												
Chief Executive's Report		x		x		x		x		x		x
Integrated Performance Report		x		x		x		x		x		x
Board Assurance Framework		x		x		x		x		x		x
Data Pack		x		x		x		x		x		x
Patient Testimony (Part 1 where possible)		x		x		x		x		x		x
Suspensions (Part 2)		x		x		x		x		x		x
Board Committee Summary Reports												
Audit Committee Report				x		x		x				x
Charity Trustee Committee Report		x		x				x		x		
Finance and Performance Committee Report		x		x		x		x		x		x
Quality and Safety Committee Report		x		x		x		x		x		x
Strategic												
Annual Operating Plan and objectives *(subject to change as dependent on national timeline)*												**x (TBC)**
Strategy Highlight Report				x		x		x		x		x
Division Progress on Strategic Clinical Priorities (Part 2)		**X (2020)**				x		x				x
Strategy Deep Dives (Part 2)		**X (2020) CSS**				**x Cancer**		**x Medicine**		**x Women and Children's**		**X Surgery**

Board Annual Cycle 2019-20

Items	*Apr 2019	May 2019	*Jun 2019	Jul 2019	Aug 2019	Sep 2019	*Oct 2018	Nov 2019	*Dec 2019	Jan 2020	*Feb 2020	Mar 2020
Sustainability and Transformation Plan (STP) (Part 2)		x		x		x		x		x		x
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report		x ***(Late May Audit Committee)***										
Annual Audit Letter						x						
Audit Committee TOR and Annual Report						**X – deferred to Nov**		X				
Raising Concerns at Work Report				x								
Review of Trust Standing Orders and Standing Financial Instructions								x				
Charity Trustee Committee												
Charity Annual Accounts and Report								x				
Charity Trust TOR and Annual Committee Review						**X – deferred to Nov**		X				
Finance and Performance Committee												
Finance Update (Part 2)		x		x		x		x		x		x
FPC TOR and Annual Report						**X – deferred to Nov**		X				
Digital Strategy Update (Part 2)		x		x		x		x		x		x
Market Strategy Review (TBC)												x

Board Annual Cycle 2019-20

Items	*Apr 2019	May 2019	*Jun 2019	Jul 2019	Aug 2019	Sep 2019	*Oct 2018	Nov 2019	*Dec 2019	Jan 2020	*Feb 2020	Mar 2020
Quality and Safety Committee												
Complaints, PALS and Patient Experience Report						x						x
Safeguarding and L.D. Annual Report (Adult and Children)				x								
Detailed Analysis of Staff Survey Results												x
Equality and Diversity Annual Report and WRES						x						
Gender Pay Gap Report												x
Learning from Deaths		x		x				x		x		
Nursing Establishment Review				x						x		
Responsible Officer Annual Review						x						
Patient Safety and Incident Report (Part 2)		x				x		x		x		
University Status Annual Report												x
QSC TOR and Annual Review						**X – deferred to Nov**		x				
Shareholder / Formal Contracts												
ENH Pharma (Part 2) [i]		x						**X - deferred to Jan**		X		

[i] To include the Annual Governance Review in November

*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.

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

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

Agenda item: 15

EAST AND NORTH HERTFORDSHIRE NHS TRUST
PUBLIC TRUST BOARD ACTIONS LOG TO 6 NOVEMBER 2019 MEETING

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
4 September 2019	19/087.1	Patient Testimony	To provide a response to the points raised during the 4 September 2019 Patient Testimony (see minutes for details).	**November 2019:** An update report is provided on the agenda	Director of Nursing / Medical Director	6 November 2019

DATA PACK

Contents

1. Data and Exception Reports:

FFT

Friends and Family Test - September 2019

APPENDIX 2

Inpatients & Day Case	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely nor Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
5A	91.67	0.00	32	23	4	0	0	1	60	101	59.41
5B	95.65	0.00	16	6	1	0	0	0	23	35	65.71
7B	87.88	0.00	36	22	8	0	0	0	66	172	38.37
8A	98.11	0.00	27	25	1	0	0	0	53	66	80.30
8B	94.64	0.00	35	18	3	0	0	0	56	113	49.56
11B	91.80	1.64	34	22	3	0	1	1	61	116	52.59
Swift	93.24	1.35	53	16	3	1	0	1	74	182	40.66
ITU/HDU	NP	NP	0	0	0	0	0	0	0	2	0.00
Day Surgery Centre, Lister	96.13	1.66	140	34	3	1	2	1	181	420	43.10
Day Surgery Treatment Centre	98.49	0.50	168	28	2	1	0	0	199	434	45.85
Endoscopy, Lister	99.67	0.00	274	30	0	0	0	1	305	1065	28.64
Endoscopy, QEII	100.00	0.00	87	7	0	0	0	0	94	305	30.82
SURGERY TOTAL	96.67	0.51	**902**	**231**	**28**	**3**	**3**	**5**	**1172**	**3011**	38.92
SSU	93.94	3.03	18	13	1	0	1	0	33	156	21.15
AMU - Blue	100.00	0.00	21	4	0	0	0	0	25	118	43.22
AMU - Green	100.00	0.00	20	6	0	0	0	0	26		
Pirton	98.08	0.00	76	26	2	0	0	0	104	104	100.00
Barley	100.00	0.00	17	3	0	0	0	0	20	29	68.97
6A	98.18	0.00	40	14	1	0	0	0	55	66	83.33
6B	89.47	0.00	9	8	2	0	0	0	19	74	25.68
11A	100.00	0.00	48	29	0	0	0	0	77	82	100.00
11A RSU	100.00	0.00	4	1	0	0	0	0	5		
ACU	100.00	0.00	19	4	0	0	0	0	23	106	21.70
10B	100.00	0.00	23	2	0	0	0	0	25	49	51.02
Ashwell	92.86	0.00	6	7	0	0	0	1	14	45	31.11
9B	95.38	0.00	41	21	1	0	0	2	65	65	100.00
9A	100.00	0.00	44	1	0	0	0	0	45	47	95.74
Cardiac Suite	100.00	0.00	43	1	0	0	0	0	44	89	49.44
MEDICINE TOTAL	98.10	0.17	**429**	**140**	**7**	**0**	**1**	**3**	**580**	**1030**	56.31
10AN Gynae	97.22	2.78	21	14	0	0	1	0	36	86	41.86
Bluebell ward	93.62	1.06	55	33	4	0	1	1	94	208	45.19
Bluebell day case	80.00	0.00	1	3	1	0	0	0	5	5	100.00
Neonatal Unit	100.00	0.00	24	2	0	0	0	0	26	67	38.81
WOMEN'S/CHILDREN TOTAL	95.03	1.24	**101**	**52**	**5**	**0**	**2**	**1**	**161**	**366**	43.99
MVCC 10 & 11	95.65	4.35	33	11	0	0	2	0	46	109	42.20
CANCER TOTAL	95.65	4.35	**33**	**11**	**0**	**0**	**2**	**0**	46	**109**	42.20
TOTAL TRUST	96.94	0.56	**1465**	**434**	**40**	**3**	**8**	**9**	**1959**	**4516**	43.38

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	96.81	0.49	1345	416	40	3	6	9	1819	4102	44.34
QEII	100.00	0.00	87	7	0	0	0	0	94	305	30.82
Mount Vernon	95.65	4.35	33	11	0	0	2	0	46	109	42.20
TOTAL TRUST	96.94	0.56	**1465**	**434**	**40**	**3**	**8**	**9**	**1959**	**4516**	43.38

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/Assessment	88.35	2.52	288	273	47	5	11	11	635	10598	5.99
QEII UCC	97.56	0.00	37	3	1	0	0	0	41	3812	1.08
A&E TOTAL	88.91	2.37	**325**	**276**	**48**	**5**	**11**	**11**	**676**	**14410**	4.69

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	92.31	7.69	6	6	0	1	0	0	13	453	2.87
Birth	98.11	0.00	83	21	1	0	0	1	106	448	23.66
Postnatal	94.34	1.89	72	28	2	1	1	2	106	448	23.66
Community Midwifery	100.00	0.00	7	1	0	0	0	0	8	434	1.84
MATERNITY TOTAL	96.14	1.29	**168**	**56**	**3**	**2**	**1**	**3**	**233**	**1783**	13.07

Outpatients	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses
Lister	93.42	1.54	510	157	31	6	5	5	714
QEII	96.27	0.77	696	181	21	2	5	6	911
Hertford County	91.68	1.50	368	183	29	2	7	12	601
Mount Vernon CC	97.87	0.00	116	22	3	0	0	0	141
Satellite Dialysis	98.77	0.00	73	7	1	0	0	0	81
OUTPATIENTS TOTAL	94.49	1.10	**1763**	**550**	**85**	**10**	**17**	**23**	**2448**

Trust Targets	% Would recommend	% response rate
Inpatients/Day Case	96%>	40%>
A&E	90%>	10%>
Maternity (combined)	93%>	30%>
Outpatients	95%>	N/A

2. Performance Data:

CQC Outcomes Summary

Our CQC Registration and recent Care Quality Commission Inspection

The Care Quality Commission inspected nine of the core services provided by East and North Hertfordshire NHS trust across Lister Hospital, the Queen Elizabeth II (QEII) Hospital and Mount Vernon Cancer Centre, between 20 and 22 March 2018. The returned on 2 April 2018 for an unannounced, follow-up inspection of the surgery core service at Lister Hospital. The well led inspection took place from 23 to 25 April 2018. The Use of Resources inspection, which is led by NHS Improvement took place on 11 April 2018.

At **Lister Hospital** CQC inspected:

- Urgent and emergency care
- Surgery
- Medicine
- Maternity
- Services for children and young people at Lister Hospital.

At the **QEII Hospital** CQC inspected:
- Urgent Care Centre

At the **Mount Vernon Cancer Centre** CQC inspected:
- Medicine
- Chemotherapy
- End of Life Care

At the October 2015 inspection, these core services were rated either as inadequate or requires improvement, apart from surgery, which was rated as good overall.

Summary of the Trust's Ratings

Our rating of the Trust stayed the same -**requires improvement**.
We were rated as **good** for caring and **requires improvement** for and safe, effective, responsive and well led.
We were rated as **requires improvement** for use of resources

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018	Good → ← Jul 2018	Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018
Queen Elizabeth II Hospital	Inadequate ➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Good ➔➔ Jul 2018	Inadequate ➔ Jul 2018	Inadequate ➔ Jul 2018
Mount Vernon Cancer Centre	Requires improvement ➔ Jul 2018	Good ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018
Hertford County Hospital	Good Mar 2016	N/A	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018
Community	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018

The CQC have issued a number of requirement notices and set out a number of areas for improvement - “Must Do’s” and “Should Do’s”.

The requirement notices are:

- Regulation 12 HSCA 2008 (Regulated Activities), Regulations 2010 Cleanliness and infection control
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing
- Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

An action plan has been developed against all of these and was submitted to CQC on 24 August 2018. This will be monitored by the Quality Improvement Board, chaired by the Medical Director or Director of Nursing and reported to Board through the Quality and Safety Committee. A programme of internal and external inspections is in place to test and evidence progress and that the actions are embedded across the organisation.

Site Ratings

Lister Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good July 2018 ↑↑	Good July 2018 ↑	Good July 2018 ↑	Good July 2018 ↑	Good July 2018 ↑↑	Good July 2018 ↑↑
Medical care (including older people's care)	Requires Improvement July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Surgery	Inadequate July 2018 ↓↓	Requires Improvement July 2018 ↓	Good July 2018 →←	Inadequate July 2018 ↓↓	Inadequate July 2018 ↓↓	Inadequate July 2018 ↓↓
Critical care	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Good March 2016
Maternity	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Good July 2018 ↑
Services for children and young people	Requires Improvement July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
End of life care	Good March 2016	Requires Improvement March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Requires Improvement March 2016
Outpatients	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←

New QEII Hospital

Urgent and emergency services	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Inadequate July 2018 ↓
Outpatients and diagnostic imaging	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Inadequate July 2018 ↓

Hertford County Hospital

Outpatients	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016

Mount Vernon Cancer Centre

Medical care (including older people's care)	Requires Improvement July 2018 ↑	Good July 2018 ↑	Good July 2018 →←	Requires Improvement July 2018 ↑	Requires Improvement July 2018 →←	Requires Improvement July 2018 ↑
End of life care	Requires Improvement July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Outpatients	Good March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Good March 2016	Good March 2016
Chemotherapy	Requires Improvement July 2018 ↓	Good July 2018 →←	Good July 2018 ↓	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Radiotherapy	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Requires Improvement July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←

Community Health Services for Children, Young People and Families

Community health services for children and young people	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016	Good March 2016

3. Quality and Safety Committee Reports:

Safer Staffing

Introduction

Whilst there is no single definition of 'safe staffing', NHS constitution, NHS England, CQC regulations, NICE guidelines, NQB expectations, and NHS Improvement resources all make reference to the need for NHS services to be provided with sufficient staff to provide patient care safely. NHS England cites the provision of an *"appropriate number and mix of clinical professionals"* as being vital to the delivery of quality care and in keeping patients safe from avoidable harm. (NHS England 2015)
East and North Hertfordshire NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives, Nursing Associates 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 using evidence based tools and professional judgement to support decisions. The National Quality Board (NQB 2016) recommend that on a monthly basis, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly.

1.0 People Productivity

The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

2.1 Nursing Fill Rate

The Trust's safer staffing submission has been submitted to NHS Digital for September within the data submission deadline. Table 1 below shows the summary of overall fill % for this month and last month and % change. The full table of fill % can be seen in Appendix 1:

There are a number of other contributory factors which affect the fill rate for September. An exception report can be found in Appendix 2 showing those wards with a Registered Fill rate below 90% and any other points of note for the month.

Table 1

	Day		Night		Average 24 Hr		
Trust Average Fill Rates	**Registered**	**Non-Registered**	**Registered**	**Non-Registered**	**Registered**	**Non-Registered**	**All Staff**
Trust Average (Current Month)	92.2%	92.6%	96.5%	112.6%	94.2%	100.3%	96.4%
Trust Average (Last Month)	94.1%	95.5%	98.2%	109.7%	95.9%	101.1%	97.8%
Change	⇩ -1.9%	⇩ -2.9%	⇩ -1.7%	⇧ 2.9%	⇩ -1.7%	⇩ -0.8%	⇩ -1.4%

2.2 Care Hours per Patient day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing.

CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care).

Registered Nursing Associates and Non-Registered Nursing Associates are now identified in separate fields within the NHS England & Improvement fill rate template. The planned care hours have been adjusted to reflect the actual care hours as the nursing associate workforce is a limited pool and the hours worked are variable each month. The total planned care

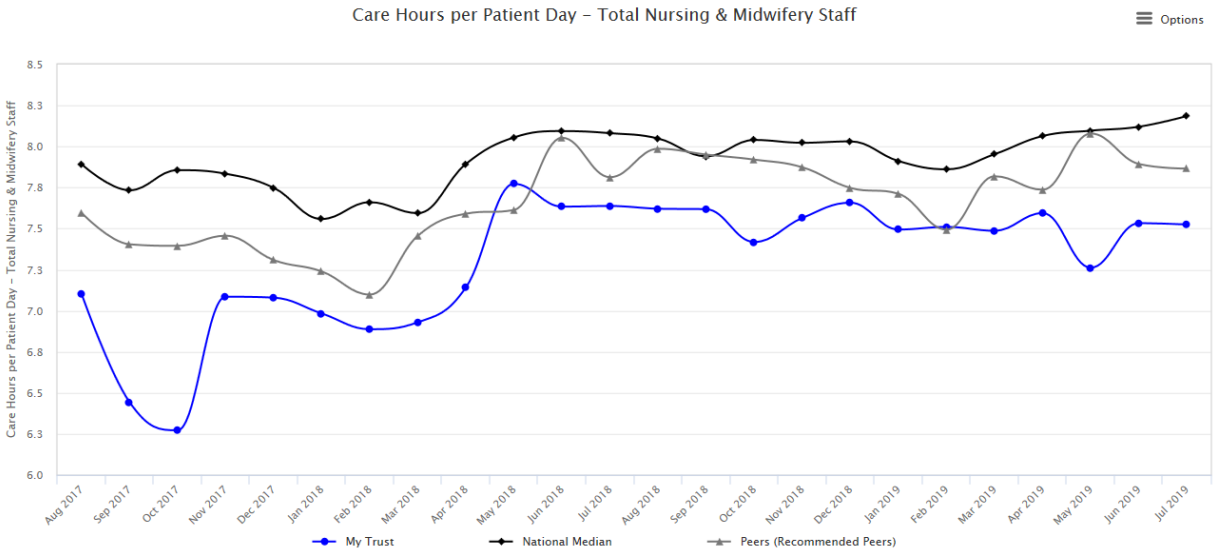
hours for each ward is fixed as per the agreed establishment settings therefore the planned hours will be flexed across Registered Nurses and Registered Nursing Associates each month.
The Trust Average CHPPD for this month and last month can be seen in the table below. A full list of CHPPD by ward can be found in Appendix 3.

Table 2

	Average 24 Hr				
Trust Average CHPPD	**Registered Nurses / Midwives**	**Non-registered Nurses / Midwives (Care Staff)**	**Registered Nursing Associates**	**Non-registered Nursing Associates**	**All Staff**
Trust Average (Current Month)	4.7	2.7	0.1	0.1	7.5
Trust Average (Last Month)	5.0	2.8	0.1	0.0	7.9
Change	↓ -0.3	↓ -0.1	→ 0.0	↑ 0.1	↓ -0.4

The chart below shows the Trust average CHPDD alongside the National Median and our peer Trusts (as recommended by the Model Hospital dashboard). This data is reviewed at Trust and Ward level as shows that we are consistently delivering less care hours per patient day than the National Median and our Peers.

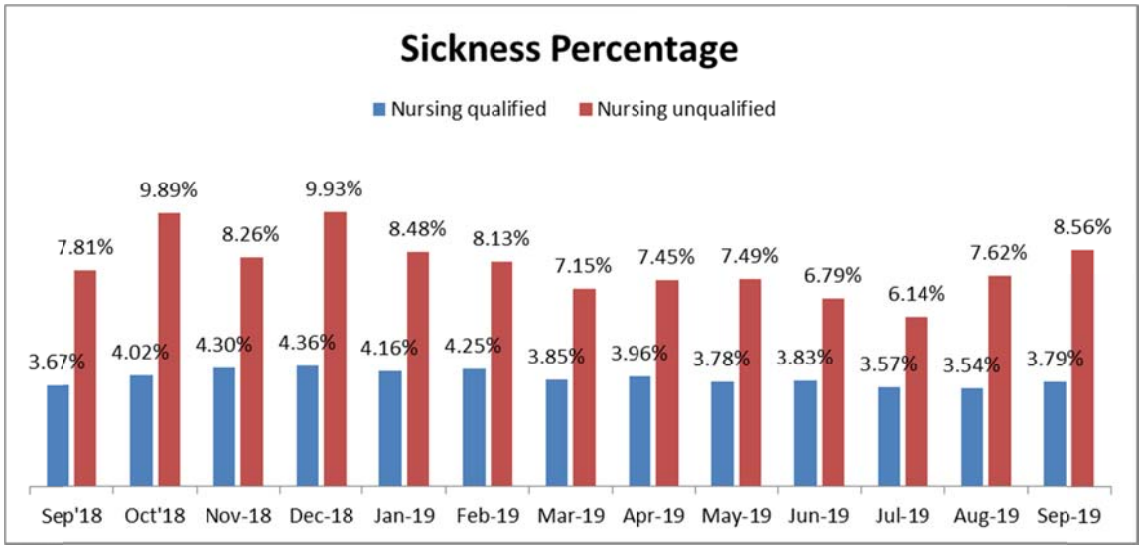
Chart 1 Care Hours per Patient Day (CHPPD): Data source Model Hospital Dashboard (latest available data).



3.3 Sickness

Chart 2 shows that sickness levels have increased both for qualified and unqualified staff in September. There is ongoing work to address our above benchmark comparator sickness levels in our CSWs.

Chart 2 – Sickness Percentage by Staff Group



3.4 Patient Flow and Escalation

Good patient flow is central to patient experience, clinical safety and reducing the pressure on staff. It is also essential to the delivery of national emergency care access standards. (NHSI 2017)
Chart 3 shows for the month of September the Opel status of the trust each day, linked with the number of Learning disability patients in acute beds and the number of enhanced care patients requiring a higher level of care per day. These factors all have an impact to staff experience, patient safety, quality and outcomes on our wards.
Where patient numbers and acuity demands on the trust increase, an informed decision to open escalation beds is made to cope with the pressures on the system. Additional staff is requested to support this requirement.
For the month of September escalation shifts were requested on 12 occasions to support the site safety and flow.

Chart 3

Sep-19		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Opel Status		OPEL 3	OPEL 3	OPEL 3	OPEL 2	OPEL 2	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 2	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 3	OPEL 2	OPEL 2	OPEL 2	OPEL 2	OPEL 2	OPEL 3	OPEL 2	OPEL 2	OPEL 2	OPEL 3	OPEL 3	OPEL 2	OPEL 2
Number of LD		4	4	5	4	6	5	5	5	6	6	5	3	5	5	5	5	8	7	9	6	4	5	8	8	9	6	8	8	8	7
Number of Enhanced Care Patients		26	26	26	20	22	18	18	18	23	24	24	24	24	24	24	25	25	25	25	28	26	19	25	30	26	30	25	20	20	25
Escalation Shifts	Discharge lounge	6A	6A	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	YES	YES	YES	NO	NO	NO	NO	NO	YES	YES	YES	YES	YES	YES	YES	NO
	CDU	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	YES	YES	YES	NO	YES	NO	NO	NO	YES	YES	YES	YES	YES	YES	YES	NO

3.5 Enhanced Care

The Enhanced Nursing care team (ENCT) are a specialist substantive team who provide enhanced care, or 1-1 and are available 24 hours a day, seven days a week, ensuring that inpatients who are at risk to themselves or others are being effectively supported by specially trained staff to feel safe, secure and cared for at all times.
For the month of September 95 risk assessments were received by the team which is a reduction of 13 patients referred compared to August. Chart 4 shows that the patients referred to the team continue to remain high. The trust is seeing a higher acuity of patients and a higher number of patients requiring enhanced care support overall compared to 2017

as shown in chart 3. The team also support mental health patients who are referred by the RAID and CCAT teams that require 1-1 enhanced care. It should be noted that a number of patients requiring enhanced care are also requiring support from our security teams. For the month of September, 225 additional hours have been used by the security team to manage patients displaying challenging behaviour 197.65 of these hours were used for a mental health patient awaiting transfer to a secure unit.
The ENCT team review all risk assessed patients on a daily basis and step the level of enhanced care up or down as required to provide a streamlined flexible service. The team continue to develop the service to ensure improved patient care and outcomes. Where demand exceeds capacity the shifts will be put out to temporary staffing to cover the requirement. Chart 5 shows the breakdown of care hours provided by the ENCT and NHS Professionals. There was one shift covered by agency to provide registered nurse support to a patient requiring 1-1specialist care on Barley ward in September. There continues to be robust check and challenge in place for all enhanced care a requirement, ensuring safe patient care is the main priority.

Chart 4

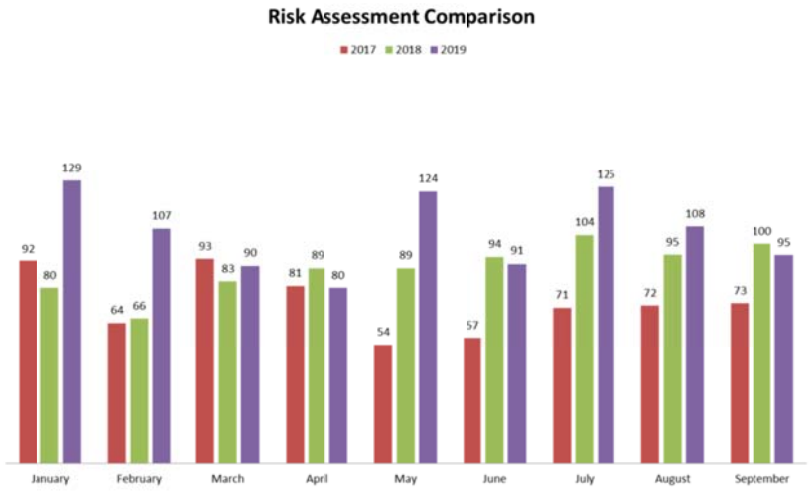
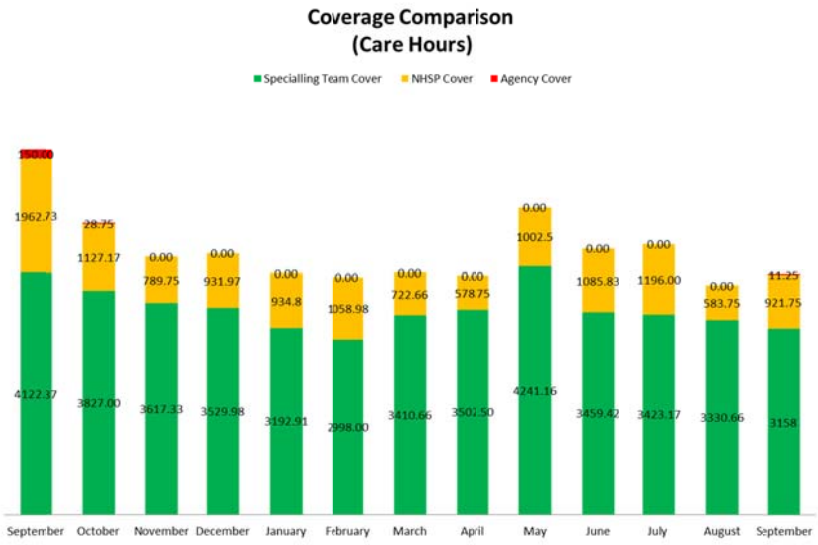


Chart 5



3.6 Recruitment and retention

The overall Trust position for qualified nursing in month 6 saw 15.9 WTE new starters and 22.3 WTE leavers, giving a negative variance of 6.4 WTE for the month. This, combined with a very small increase in recruitable establishment of 0.6 WTE, has resulted in an increased vacancy rate of 6.5%, an increase of 0.7% from month 5.

The vacancy rate for CSWs increased in month 6 to 10.8%, equating to 67 vacancies. There are a total of 28 WTE in the pipeline currently undergoing pre-employment checks, 21 with confirmed start dates in month 8.

4.0 Financial Sustainability

The Deputy Director of Nursing, all matrons, safer staffing team and heads of nursing continue to meet monthly to prospectively review rosters to identify operational shortfalls and temporary staff requirements including agency usage/ requirements. Each ward is then RAG rated on a heat map and agency levels and restrictions agreed. Any additional ad hoc agency requirements outside of this meeting are authorised via the Director of Nursing or Deputy Director of Nursing.

Should a ward need to go above their planned agency usage a robust process is in place to be agreed by the director or deputy director of nursing.

To facilitate the reduction in agency costs, the trust continue to use a Rapid Response pool of nurses and CSWs. These bank staffs get an enhanced pay rate and flexible hours in recognition of the workers commitment to be deployed to any clinical area at the time of reporting for work. The Rapid Response pool is used to mitigate daily staffing challenges such as sickness and short notice drop out to ensure wards are staffed safely. The number of shifts available are flexed up or down as the need arises. This initiative has been recognised nationally as an innovative workforce model and has won an award for innovative workforce models for better patient care at the Allocate workforce conference in October 2019.

4.1 Temporary Staffing Fill

Overall fill rate for temporary staffing decreased by 0.2% from 80.0% in August to 79.8% in September. Demand hours decreased by over 1,300 hours.

Bank fill rates increased by 0.3% and Agency fill rates decreased by 0.5%. The level of unfilled shifts increased from 20.0% in August to 20.2% in September.

Table 3 Temporary Staffing Registered and Unregistered Hours Demand and Fill Rates

Current YTD Month & Year	Net Hours Requested *	NHSP Filled Hours	% NHSP Filled Hours	Agency Filled Hours	% Agency Filled Hours	Overall Fill Rate	Unfilled Hours	% Unfilled Hours
April 2019	64,841	46,309	71.4 %	4,405	6.8 %	78.2 %	14,126	21.8 %
May 2019	67,192	49,578	73.8 %	5,049	7.5 %	81.3 %	12,566	18.7 %
June 2019	61,653	46,272	75.1 %	4,434	7.2 %	82.2 %	10,947	17.8 %
July 2019	55,414	49,279	88.9 %	3,498	6.3 %	95.2 %	2,637	4.8 %
August 2019	63,744	48,398	75.9 %	2,571	4.0 %	80.0 %	12,776	20.0 %
September 2019	65,136	49,629	76.2 %	2,325	3.6 %	79.8 %	13,183	20.2 %
Total	**377,981**	**289,465**	**76.6 %**	**22,282**	**5.9 %**	**82.5 %**	**66,234**	**17.5 %**

Chart 5 Nursing and Midwifery Temporary Staffing Demand and Fill Rates

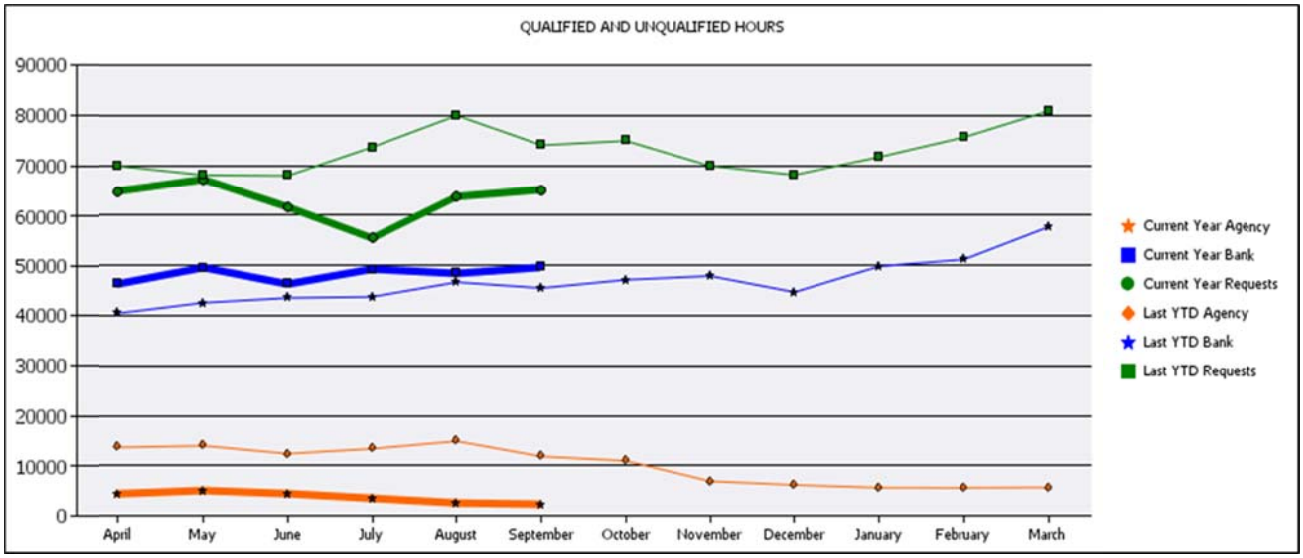


Table 4 Temporary Staffing Registered Hours Demand and Fill Rates

Current YTD Month & Year	Net Hours Requested *	NHSP Filled Hours	% NHSP Filled Hours	Agency Filled Hours	% Agency Filled Hours	Overall Fill Rate	Unfilled Hours	% Unfilled Hours
April 2019	39,531	26,870	68.0 %	4,405	11.1 %	79.1 %	8,256	20.9 %
May 2019	40,785	28,116	68.9 %	5,049	12.4 %	81.3 %	7,621	18.7 %
June 2019	38,598	26,925	69.8 %	4,434	11.5 %	81.2 %	7,239	18.8 %
July 2019	33,439	27,978	83.7 %	3,498	10.5 %	94.1 %	1,963	5.9 %
August 2019	39,063	28,388	72.7 %	2,571	6.6 %	79.3 %	8,104	20.7 %
September 2019	40,667	29,730	73.1 %	2,325	5.7 %	78.8 %	8,612	21.2 %
Total	**232,083**	**168,006**	**72.4 %**	**22,282**	**9.6 %**	**82.0 %**	**41,795**	**18.0 %**

Table 5 Temporary Staffing Unregistered Hours Demand and Fill Rates

Current YTD Month & Year	Net Hours Requested *	NHSP Filled Hours	% NHSP Filled Hours	Agency Filled Hours	% Agency Filled Hours	Overall Fill Rate	Unfilled Hours	% Unfilled Hours
April 2019	25,309	19,439	76.8 %	0	0.0 %	76.8 %	5,871	23.2 %
May 2019	26,408	21,463	81.3 %	0	0.0 %	81.3 %	4,945	18.7 %
June 2019	23,055	19,346	83.9 %	0	0.0 %	83.9 %	3,709	16.1 %
July 2019	21,975	21,301	96.9 %	0	0.0 %	96.9 %	674	3.1 %
August 2019	24,682	20,011	81.1 %	0	0.0 %	81.1 %	4,671	18.9 %
September 2019	24,469	19,899	81.3 %	0	0.0 %	81.3 %	4,570	18.7 %
Total	**145,898**	**121,458**	**83.2 %**	**0**	**0.0 %**	**83.2 %**	**24,440**	**16.8 %**

4.2 Roster KPIs

Table 6 shows the roster KPIs for the month of September as captured in the Nursing Quality Indicators Report. All Divisions were within the recommended Annual Leave threshold of 13-17%. There is ongoing work with divisions to improve their roster KPIs through the eRoster and Finance Master Classes currently being rolled out to Ward Managers and Matrons.

Table 6 eRostering KPIs

SUMMARY		Trust	Medicine	Surgery	Women & Children	Cancer	Assessment Wards	Emergency Department	Dialysis
e-Roastering	% E-roster Deadline Met	45.71%	38.67%	66.38%	33.00%	33.00%	33.00%	49.50%	66.40%
	Net Hours %	-0.11%	0.32%	0.74%	0.06%	-0.70%	0.10%	-0.70%	-0.58%
	Net Hours Position	271.74	134.40	270.53	73.42	-38.93	13.01	-67.16	-113.53
	% of Actual Annual Leave	14.43%	14.21%	15.00%	15.97%	13.60%	13.20%	13.75%	15.26%

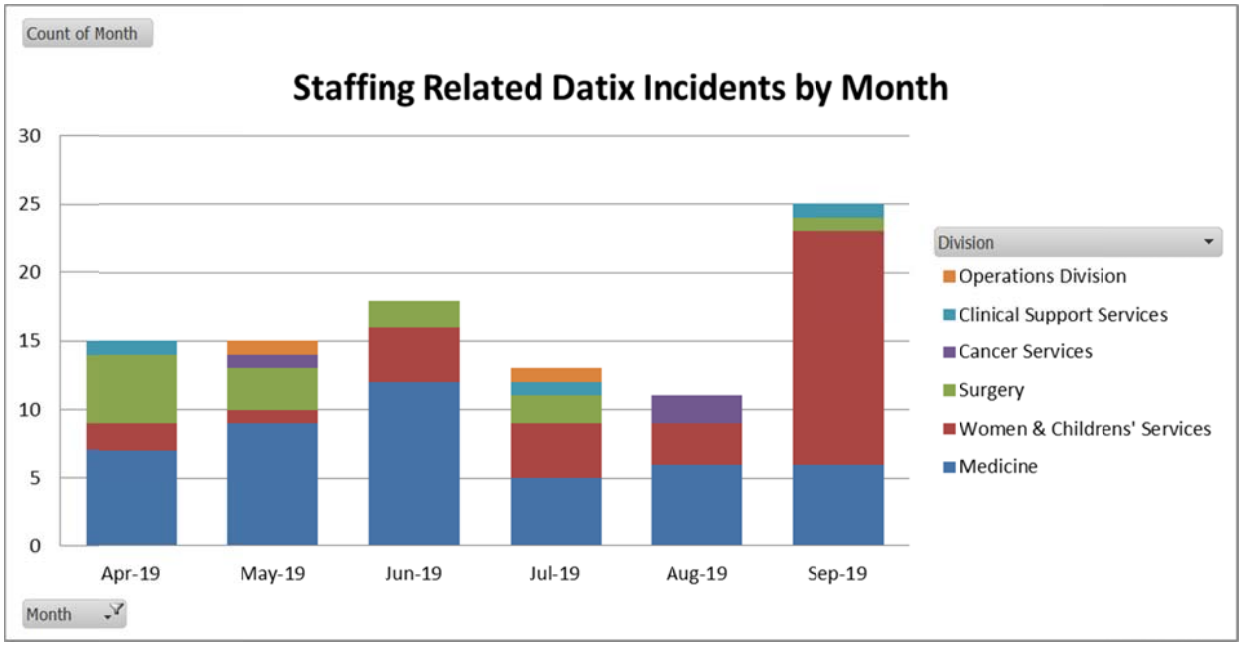
5.0 Investigations and actions on Incidents and red flag events

Shifts that fall below minimum staffing levels are escalated to the divisional staffing bleep holder who moves staff to balance risk across the division. Where the individual division is unable to mitigate independently this is escalated to the Divisional Heads of Nursing to balance risk across the organisation.

5.1 Datix Incidents

Chart 6 shows the number of staffing related Datix incidents logged in the last six months by speciality.
Twenty-five staffing related Datix were raised in September. All staffing related incidents are reviewed by the Safer Staffing Matron and DoN and actioned as appropriate. All Datix for September have been reviewed and actioned by the department managers.
To note there was an increase in incidents reported for maternity services due to increased activity in month.

Chart 6



5.2 Red Flag Events

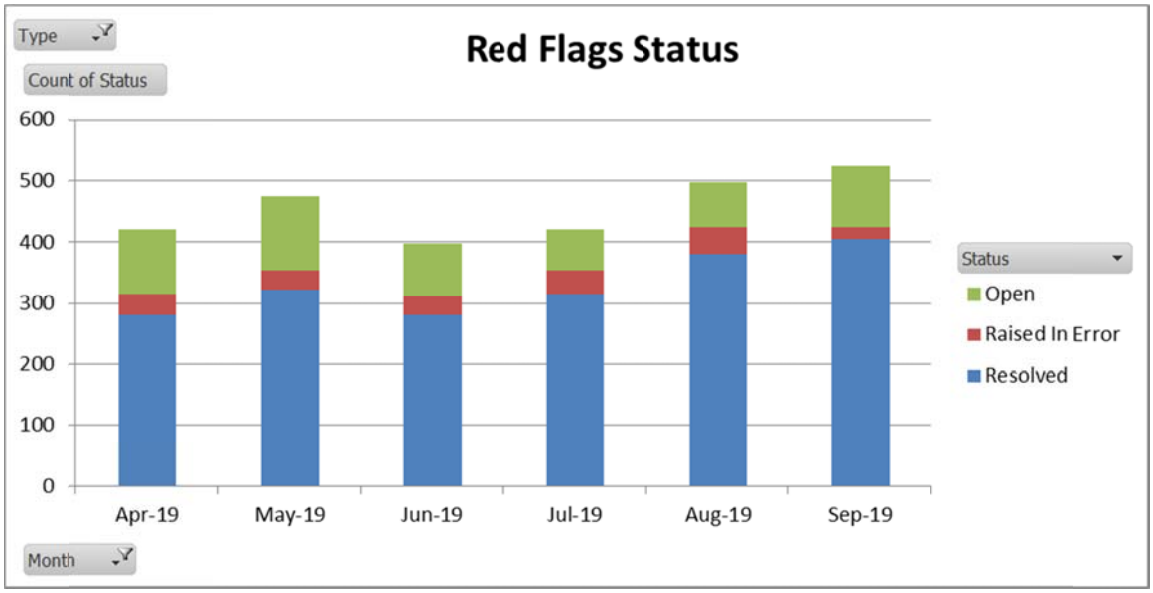
Red flags are NICE recommended nationally reportable events that require an immediate response from the Senior Nurse Team. "Red flag events" signal to the Senior Nurse Team an urgent need for review of the numbers of staff, skill mix and patient acuity and numbers. These events are considered as indicators of a 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.
Red flag notifications are completed in SafeCare and sent to a centralised staffing e-mail address. These notifications are then escalated at each of the three daily staffing meetings and site safety meeting, and closed once actions to mitigate are in place. The nurse in charge of the ward will try to resolve Red Flags with the help of the Divisional bleep holders who will act on escalated 'open' issues to help resolve them. Feedback from the wards has found the red flags are appropriate to the staffing challenges they need to escalate on a shift.

The Safer Staffing Team commenced work with the Maternity Services Team at the end of January and has set up Red Flag Events: signs that there may not be enough midwives available as per NICE guidance. The midwife in charge can now record red flag events and the action taken as a result using SafeCare. See **Appendix 4** for the Midwifery safe staffing update.

Chart 7 below shows the number of red flags raised each month over the last 6 months and their status excluding Maternity Red Flags.

Chart 7



6.0 Patient outcomes

The Safer Staffing Team continues to monitor staffing at the three Daily Staffing meetings and weekly staffing look ahead meetings. Daily site safety meetings give a site overview of current issues and concerns relating to capacity, quality, patient care and safety concerns. This supports multi-professional informed decision making across the day. In addition to this there is a weekly look ahead meeting to ensure early mitigation / shift changes are agreed to pro-actively cover shortfalls.

6.1 Safety Thermometer

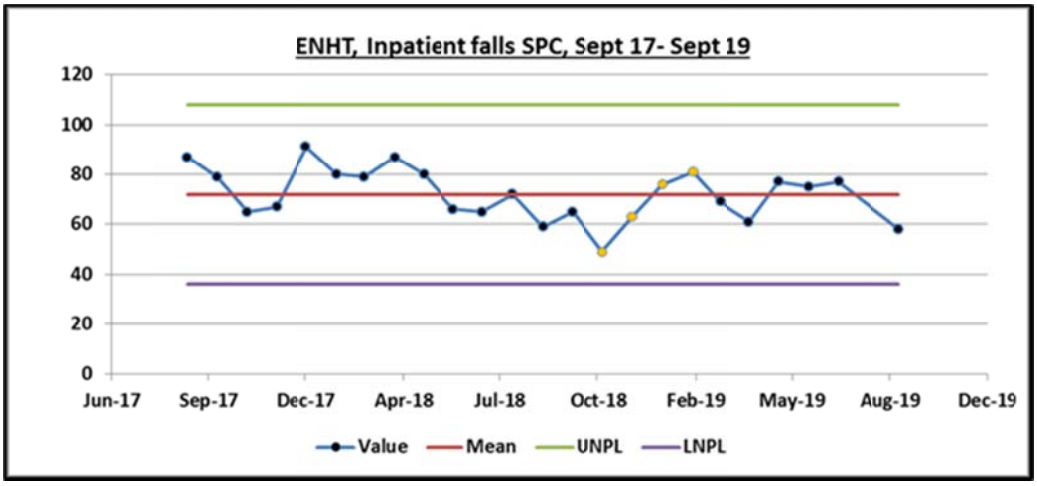
The NHS Safety Thermometer audit provides a 'temperature check' on levels of harm and enables the measurement of 'harm free care'. Harm free care is defined by the absence of pressure ulcers, harm from a fall, urine infection (in patients with a catheter)

and new VTE. This report details the number of patients 'with harm' on the specified audit date – 18th September 2019. We acknowledge that the 'harm' in September may not have occurred on the ward that it is captured on and therefore encourage all wards/Divisions to discuss the root cause analysis of all harms across Divisions. When looking at benchmarking data from the NHSI model hospital dashboard, as a trust we are in the top quartile for harm free care.

6.2 Falls

58 inpatient falls were recorded in the Trust during September which is a decrease of 12 incidents when compared to August as shown in chart 8. There is ongoing work to continue to improve our prevention of falls with the promotion of the Bay watch initiative and compliance with the policy.
The Trust is currently 11 incidents below the targeted reduction trajectory set for 2019/20.

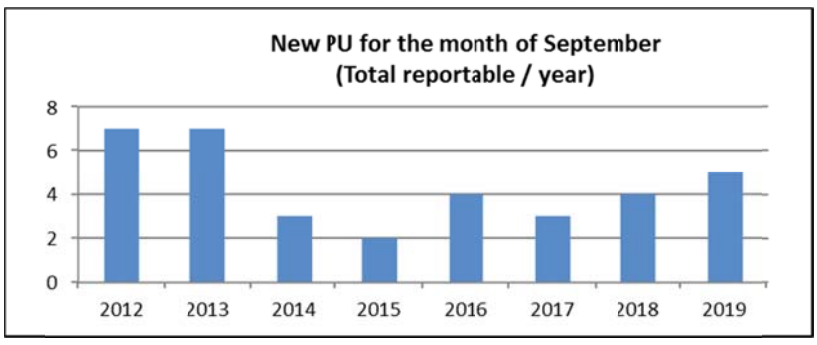
Chart 8



6.3 Pressure Ulcers

For the month of September there were 5 new pressure ulcers (all categories). In compliance with the new NHSI Pressure ulcer (PU) recommendations suspected deep tissue injury (SDTI) numbers are now incorporated into main reporting figures.
September 2019 figure incorporates all categories of damage where 2012-2017 only counts category 2-4 and unstageable ulcers shown in Chart 9.
The graph depicts total number of reportable pressure ulcers per year.
2018-19 Total = 86, Current YTD = 69

Chart 9



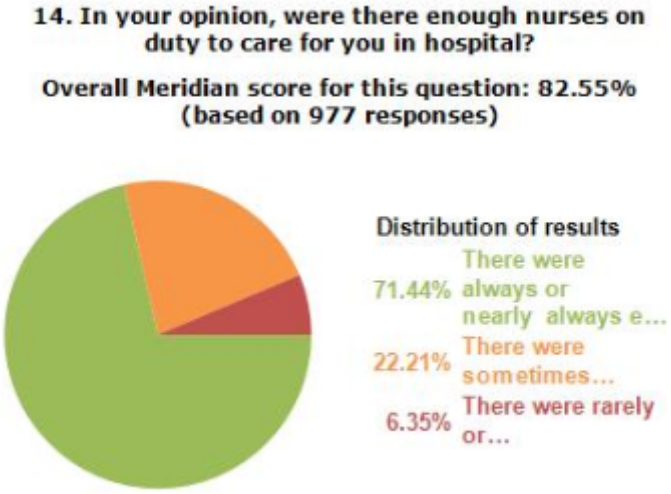
7.0 Patient, carer and staff feedback in relation to safe staffing levels

The trust asks the question within our Inpatient survey 'In your opinion, were there enough nurses on duty to care for you in hospital? In September 2019, 6.35% of 977 responses felt there were not enough nurses on duty. This is an increase in patients/carers feeling there weren't enough nurses on duty from 3.7% in August.

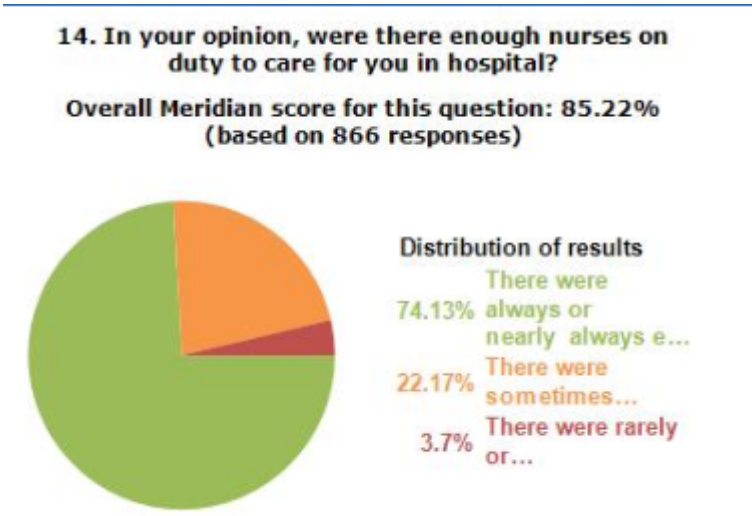
Chart 10 shows the breakdown of responses for September 2019 compared to August 2019.

Action plans are put in place where performance is triggering red.

Chart 10
September 2019



August 2019



7.1 Friends and Family

Table 7 shows the results for the friends and family test for the past 3 months. The percentage of patients that would recommend our trust for the month of September has increased slightly from August.

Table 7

A Summary of the last 3 months responses

Month	% Would Recommend	% Would Not Recommend	No. of patients responding	% response rate [target 40%]
July 2019	**97.83**	**0.80**	2263	**45.44**
August 2019	**96.88**	**0.97**	1760	**39.94**
September 2019	**96.94**	**0.56**	1959	**43.38**

8.0 Recommendations

- Note the information on the nurse and midwifery staffing and the impact on quality and patient safety
- Note the content of the report and that mitigation is put in place where staffing levels are below planned.
- Note the content of the report is undertaken following national guidelines using research and evidence based tools and professional judgement to ensure staffing is linked to patient safety and quality outcomes.
- Note the ongoing requirement to continue to source and recruit registered and unregistered staff to match our staffing establishments and reduce our reliance on temporary staffing.

References

Letter from Chief Nursing Officer (NHS England) to Chief Executives of Health Education England and NHS England, dated 3 September 2015
NQB (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing.
Good practice guide: Focus on improving patient flow NHSI August (2017)

Appendix 1

	Day				Night			
Ward name	Average fill rate + registered nurses/ midwives (%)	Average fill rate + care staff (%)	Average fill rate - Registered Nursing Associates	Average fill rate - Non - Registered Nursing Associates	Average fill rate + registered nurses/ midwives (%)	Average fill rate + care staff (%)	Average fill rate - Registered Nursing Associates	Average fill rate - Non - Registered Nursing Associates
10B	93.3%	101.2%	100.0%	100.0%	95.4%	130.9%	#DIV/0!	100.0%
11A	97.9%	106.9%	#DIV/0!	#DIV/0!	96.0%	133.7%	#DIV/0!	#DIV/0!
11B	78.6%	95.2%	100.0%	#DIV/0!	100.0%	110.8%	#DIV/0!	#DIV/0!
5A	96.1%	81.8%	100.0%	100.0%	98.8%	106.0%	#DIV/0!	#DIV/0!
5B	87.2%	89.7%	100.0%	100.0%	93.0%	118.6%	#DIV/0!	100.0%
6A	97.3%	87.6%	#DIV/0!	100.0%	97.9%	109.0%	#DIV/0!	#DIV/0!
6B	93.4%	92.3%	#DIV/0!	100.0%	97.3%	107.0%	#DIV/0!	#DIV/0!
10A Gynae	100.5%	81.9%	#DIV/0!	#DIV/0!	98.4%	103.3%	#DIV/0!	#DIV/0!
7B	97.9%	89.1%	100.0%	100.0%	98.5%	103.0%	#DIV/0!	100.0%
8A	91.4%	102.2%	100.0%	#DIV/0!	97.1%	106.4%	#DIV/0!	#DIV/0!
8B	104.4%	87.3%	#DIV/0!	100.0%	98.3%	109.5%	#DIV/0!	#DIV/0!
9A	95.6%	110.3%	100.0%	#DIV/0!	97.7%	133.1%	100.0%	#DIV/0!
9B	98.8%	106.9%	#DIV/0!	#DIV/0!	100.5%	138.8%	#DIV/0!	#DIV/0!
ACU	92.6%	110.1%	#DIV/0!	100.0%	94.5%	129.0%	#DIV/0!	#DIV/0!
AMU-A	93.9%	89.2%	100.0%	#DIV/0!	94.7%	103.4%	100.0%	#DIV/0!
AMU-W	94.6%	108.7%	#DIV/0!	#DIV/0!	101.0%	106.7%	#DIV/0!	#DIV/0!
Ashwell	90.1%	110.2%	100.0%	100.0%	100.7%	136.4%	100.0%	#DIV/0!
Barley	101.1%	118.2%	#DIV/0!	#DIV/0!	101.6%	152.2%	#DIV/0!	#DIV/0!
Bluebell	98.0%	84.7%	100.0%	100.0%	97.8%	98.2%	#DIV/0!	#DIV/0!
Critical Care 1	100.0%	100.0%	#DIV/0!	#DIV/0!	100.0%	100.0%	#DIV/0!	#DIV/0!
Dacre	95.3%	75.1%	#DIV/0!	#DIV/0!	94.5%	#DIV/0!	#DIV/0!	#DIV/0!
Gloucester	94.0%	78.2%	#DIV/0!	#DIV/0!	98.9%	98.3%	#DIV/0!	#DIV/0!
Mat CLU 1	90.1%	84.2%	#DIV/0!	#DIV/0!	100.2%	82.5%	#DIV/0!	#DIV/0!
Mat MLU	77.4%	82.4%	#DIV/0!	#DIV/0!	76.5%	96.4%	#DIV/0!	#DIV/0!
Pirton	82.7%	99.5%	#DIV/0!	#DIV/0!	100.7%	111.6%	#DIV/0!	100.0%
SAU	93.0%	88.4%	#DIV/0!	100.0%	98.2%	99.9%	#DIV/0!	100.0%
SSU	95.5%	96.7%	#DIV/0!	100.0%	98.2%	116.1%	#DIV/0!	#DIV/0!
Swift	78.7%	88.5%	100.0%	#DIV/0!	99.0%	95.2%	#DIV/0!	#DIV/0!
Ward 11	66.8%	47.2%	100.0%	#DIV/0!	74.8%	102.3%	#DIV/0!	#DIV/0!
Total	**92.0%**	**92.3%**	**100.0%**	**100.0%**	**96.5%**	**112.7%**	**100.0%**	**100.0%**

Appendix 2

Ward Staffing Exception Report

Wards with a Registered fill rate <90%, and wards where the planned staffing differs from actual.

Ward	Comment
5B	Reduced occupancy in month
11B	Reduced occupancy in month
Pirton	Reduced occupancy in month
Swift	Reduced occupancy in month
Ward 11	Reduced occupancy in month, staffing flexed across the Cancer Services Division to support safe staffing
MLU	Low occupancy in month, staffing flexed across the Maternity Service to meet patient needs

Appendix 3

Ward name	Care Hours Per Patient Day (CHPPD)				
	Registered midwives/ nurses	Care Staff	Registered Nursing Associates	Non-Registered Nursing Associates	Overall
10B	3.17	2.48	0.09	0.20	5.94
11A	3.83	2.32	0.00	0.00	6.15
11B	4.06	2.79	0.09	0.00	6.95
5A	3.49	2.09	0.05	0.13	5.75
5B	3.51	2.82	0.13	0.03	6.49
6A	3.37	2.21	0.00	0.13	5.70
6B	4.52	2.20	0.00	0.01	6.72
10A Gynae	5.94	2.77	0.00	0.00	8.71
7B	3.27	2.00	0.18	0.08	5.53
8A	3.03	2.13	0.14	0.00	5.30
8B	3.34	2.06	0.00	0.14	5.53
9A	3.06	2.62	0.11	0.00	5.79
9B	3.03	2.66	0.00	0.00	5.69
ACU	4.41	2.56	0.00	0.23	7.20
AMU-A	6.51	3.82	0.25	0.00	10.58
AMU-W	4.28	3.11	0.00	0.00	7.39
Ashwell	3.15	3.17	0.24	0.17	6.72
Barley	3.57	3.55	0.00	0.00	7.12
Bluebell	7.40	2.36	0.48	0.39	10.64
Critical Care 1	18.27	1.87	0.00	0.00	20.14
Dacre	7.22	0.94	0.00	0.00	8.16
Gloucester	4.67	4.09	0.00	0.00	8.76
Mat CLU 1	20.00	5.76	0.00	0.00	25.76
Mat MLU	27.00	9.95	0.00	0.00	36.96
Pirton	4.57	2.65	0.00	0.02	7.24
SAU	7.50	3.19	0.00	0.41	11.10
SSU	3.43	3.35	0.00	0.07	6.84
Swift	4.44	2.65	0.15	0.00	7.24
Ward 11	5.23	2.75	0.22	0.00	8.20
Total	**4.7**	**2.7**	**0.1**	**0.1**	**7.5**

Appendix 4

Safer Staffing Report September 2019

Planned versus actual midwifery staffing levels

NHSR Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Evidence:

- Details of planned versus actual midwifery staffing levels.
- The midwife: birth ratio.

Funded Clinical Establishment supports an annual ratio of 1 midwife to 29 women (includes band 3 and 4 staff that support postnatal care). Ratios will vary month on month due to variations in birth numbers however the funded establishment supports all maternity activity both hospital and community care.

2019	June		July		Aug		Sept	
Midwives	178.57		178.57		178.57		178.57	
Band 3-4 Postnatal	11.53		11.53		11.53		11.53	
Total Funded Clinical	**190.1**		**190.1**		**190.1**		**190.1**	
Actual Worked	**184.36**		**178.34**		**178.34**		**176.29**	
	Births	**Ratios**	**Births**	**Ratios**	**Births**	**Ratios**	**Births**	**Ratios**
Predicted Births in month based on number of women EDD 4 months' time against funded* Clinical Establishment	442	**29**	460	**28.5**	454	**28**	**440**	28
12 Month Rolling Year to Date Against Funded Midwifery Establishment	5312	**30**	5317	**30**	5318	**30**	**5327**	28
Actual Births in Month against actual worked in month midwives	5195	**30**	5439	**32.5**	5228	**32**	5487	**33**

Total Clinical WTE funded	<30.5	Midwife only funded	<31.5
to a ratio of 1:29	30.6-32	to a ratio of 1:31	31.6-33
based on 5500 births	>32	based on 5500 births	>33

*From April 2019 included in the clinical numbers are non-recruitable 4.76 in budget to support maternity leave

Also included 4% non recruitable headroom

Actions

- Birthrate Plus (BR+) Workforce Analysis based on QTR 3 18/19 activity recommended an uplift in establishment (not including requirements to support national maternity transformation ambitions)
- Presented to Trust Board in July 2019 as part of the Trust Bi-annual Establishment Review reflecting professional judgment to inform recommended uplift
- Local Maternity System funds utilised to support maternity transformation workforce ambitions and increase establishment
- BR+ recommendations shared across the LMS
- Draft LMS 5 Year Workforce Strategy to be shared with the STP
- A maternity staffing paper to be presented to execs in October 2019

Midwifery red flag events

NHSR Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Evidence:

Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising (Please note: it is for the trust to define what red flags they monitor).

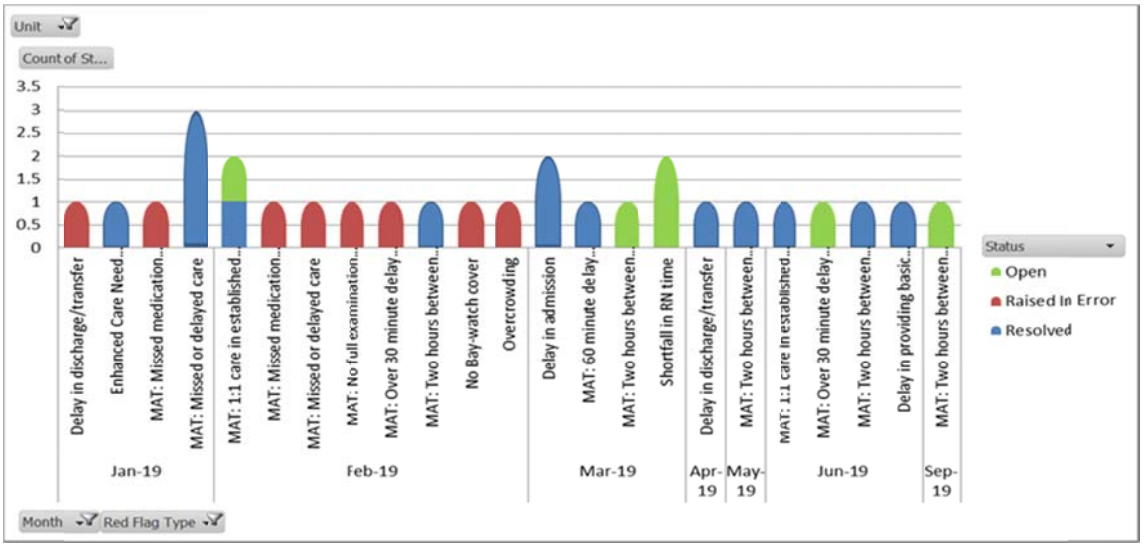
NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as negative events that are immediate signs that something is wrong and action is needed now to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service and the response may include allocating additional staff to the ward or unit.

Red Flags are captured as part of the role of the manager of the day and the capture of red flags by the Senior Midwife on the shift on SafeCare from January 2019 will support this process

The Red Flags recommended by NICE

Missed medication during an admission
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Delay of 60 minutes or more between delivery and commencing suturing
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for IOL and commencing the IOL process
Delayed recognition/ action of abnormal observations as per OEWS
1:1 care in established labour not provided to a woman

Maternity Red Flags



East and North Hertfordshire NHS Trust

Agenda Item: 17.1

TRUST BOARD - PUBLIC SESSION – 6 NOVEMBER 2019
CHARITY TRUSTEE COMMITTEE – 9 SEPTEMBER 2019
EXECUTIVE SUMMARY REPORT

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

To present to the Trust Board the summary report from the Charity Trustee Committee (CTC) meeting of 9 September 2019.

The report includes details of any decisions made by the CTC under delegated authority.

Action required: For information

Previously considered by:
Due to be considered by Corporate Trustee prior to public meeting of Trust Board on 6 November 2019.

Director:	**Presented by:**	**Author:**
Chair of CTC	Chair of CTC	Board Committee Secretary / Trust Secretary

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

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

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

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

CHARITY TRUSTEE COMMITTEE MEETING HELD 9 SEPTEMBER 2019

SUMMARY REPORT TO BOARD

The following members were present: Bob Niven (CTC Chair), Val Moore (Non-Executive Director), David Buckle (Non–Executive Director Associate) and Sarah Brieley (Director of Strategy).

Key Decisions made under delegated authority:

There were no decisions made under delegated authority at this meeting.

Other outcomes:

Divisional Fund Management Reports – Medicine
The Committee considered a report regarding the deployment of the Medicine Division's charitable funds. The Division reported on the current position in terms of fund management and future plans. They reported on the "forget me not" project and the recruitment of a volunteer activity coordinator for the Butterfly Project to coordinate volunteers who accompany patients receiving palliative care.

The Committee suggested that a breakdown of the Division's progress since the previous year would be helpful for future reports.

Applications for expenditure over £5,000
There were no applications for expenditure over £5,000. Projects approved by CMT were presented to the Committee for information.

John Bush Legacy
The Committee considered a report regarding expenditure against the John Bush Research Fellow Award for the period May 2018-Aug 2019. It was reported that a total of four applications have been approved in the period.

The CTC discussed the governance around the process of approval and recommended that consideration was given to appointing a lay member to the panel.

MVCC Update
The Committee was provided with an update on Mount Vernon Cancer Centre. The paper was provided to update the Committee on the strategic review undertaken by NHSE Specialist Commissioners into the sustainability of oncology services provided by the Mount Vernon Cancer Centre. One of the recommendations was for the management of the service to be transferred to a tertiary provider.

The Committee would consider the effects of the above on the Charity and consider next steps and actions at future meetings.

Review of Charity Strategy Progress
The CTC reviewed an update on the progress of the charity strategy. The Committee discussed legacy promotion to generate more income, staff lottery and Charity ambassadors.

The Committee recommended that the communication team attend the next meeting to discuss the development of a communication strategy for the Charity.

Charity Finance Report
The CTC considered the report which provided an update on the financial performance of the Charity. The report provided an update on the closing finance position of the Charity for Month 5.

As at 31st July 2019, year to date income was £240k (plan £476k). Expenditure was £598k (plan £516k). This resulted in an adverse position of £358k (plan adverse £41k). The year to date income is after an accounting adjustment for legacy income (£164k) accrued in 2017/18 but no longer receivable due to conditions attached. Therefore, excluding this, year to date income was £403k (plan £476k).

The Committee requested that the Head of Charity present plans for delivering the income target for the year at the next meeting.

Draft Charity Annual Report and Accounts
The CTC was presented with an early draft version of the annual report and accounts for 2018/19 for consideration. It was the intention that this would be presented to the Board in November for approval.

CTC Annual Review
The CTC considered the annual review of the effectiveness of the CTC and its terms of reference.

The Committee supported the annual review and recommendations, including the undertaking of a governance review, and requested some minor updates to the terms of reference in terms of membership and quorum.

Investment Portfolio Update
The Committee noted the investment portfolio update. The Chair would write to the investment advisors regarding the performance of the portfolio and to outline the position in terms of strategic review of MVCC.

Bob Niven
Chairman of the Charity Trustee Committee

September 2019

East and North Hertfordshire NHS Trust

Agenda Item: 17.1.1

TRUST BOARD - PUBLIC SESSION – 6 NOVEMBER 2019
CHARITY TRUSTEE COMMITTEE ANNUAL REVIEW 2018-19

Purpose of report and executive summary (250 words max):
The purpose of the report is to provide the findings Charity Trustee Committee annual review for 2018-19.

The report concludes that the Charity Trustee Committee met its duties under its terms of reference but makes the following recommendations to further strengthen the Committee:

- To aim to reduce the number of approvals that are sought by email.
- To undertake a review of the Charity governance to ensure the CTC remains in line with Charity Commission guidance.
- To ensure that the Committee is kept abreast of pertinent developments regarding the transfer of Mount Vernon Cancer Centre.

The Board is asked to approve the annual review and revised terms of reference.

Action required: For information

Previously considered by:
CTC – 09.09.19
Due to be considered by Corporate Trustee prior to public meeting of Trust Board on 6 November 2019

Director:	**Presented by:**	**Author:**
Associate Director of Corporate Governance	CTC Chair	Trust Secretary

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Not directly

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

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

CHARITY TRUSTEE COMMITTEE ANNUAL REVIEW 2018-19

Executive Summary

The Charity Trustee Committee (CTC) is a Committee of the Board in its role of Corporate Trustee. The purpose of the CTC is to:

- ensure a robust strategy for the delivery of the Charity aims and objectives;
- champion the Charity and its development, providing leadership both within the Trust and externally;
- provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies.

These are delegated duties carried out on behalf of the East and North Hertfordshire NHS Trust, which is the sole *Corporate Trustee* of East and North Herts Hospitals Charity (registered charity no. 1053338).

This annual review of the CTC considers how the Committee has met its duties under its Terms of Reference throughout 2018-19. The review has been drafted by the committee secretariat and agreed with the CTC Chair. A review of the Committee's minutes and reports to Board, a review of the Standing Orders and Standing Financial Instructions and the results of a self-assessment survey have been used to inform this report.

The overall conclusion of the annual review is that the Committee has successfully met its duties and responsibilities over the period, and the consensus from the self-assessment survey was that improvements have been made in a number of areas.

In order to improve the effectiveness of the Committee further over 2019-20, the following recommendations are highlighted from the review:

- To aim to reduce the number of approvals that are sought by email.
- To undertake a review of the Charity governance to ensure the CTC remains in line with Charity Commission guidance.
- To ensure that the Committee is kept abreast of pertinent developments regarding the completion of the actions from the MVCC Clinical Advisory Group Report.

The CTC is asked to recommend the report and the revised terms of reference (which have been reviewed and minor changes proposed – see Appendix 1) for approval by the Trust Board.

Summary of key findings:

Meetings and membership:

The CTC met four times during 2018-19 and all meetings were quorate under the current Terms of Reference. The attendance of core members is recorded in the East and North Hertfordshire's NHS Trust Annual Report. Since joining the Trust in September 2018, Dr David Buckle, Non-Executive Director, Associate, has also been attending the CTC meetings. The finance representatives at the meetings have been the Financial Controller and Charity Finance Manager.

During the course of 2018-19 the Executive Director lead for the Charity changed from the Director of Strategy to the Director of Nursing as an interim arrangement following the departure of the previous Director of Strategy in January 2019. The Charity has now moved back to the strategy directorate following the appointment of a permanent Director of Strategy in June 2019.

In 2018-19 there were several occasions where decisions had to be agreed by email as decisions were needed prior to the next CTC meeting. This should only happen in exceptional circumstances so as to ensure that the correct governance processes are followed.

CTC member survey:
As part of the review process, a survey was sent to the regular attendees of the CTC meetings in 2018-19 to gather their feedback on the effectiveness of the Committee and areas for improvement.

The key findings from the survey were:

- There was agreement that the agenda covers the right items
- It was felt that the reports generally provide the right level of information. It was suggested that there was some scope to improve the divisional reports.
- It was felt that there is good open discussion at the meetings
- All respondents felt that the Committee provides good stewardship of charitable resources and compliance with the Charity governance and Trust policies. It was suggested that a review of the Charity governance to ensure the CTC remains in line with Charity Commission guidance.
- It was mostly felt that there was good challenge at the meeting, though possibly scope for further improvement
- There were few areas for improvement identified from the survey.

In terms of performance against the recommendations made in last year's annual review, the respondents' feedback is provided in the table below:

Recommendation	Survey feedback
To develop a clear statement of charity criteria and priorities	It was felt that good progress had been made in this area
To have a draft minutes and actions log available to within two weeks of the meetings to support he work programme	It was recognised that this had not been consistently achieved
To explore more concise reports with the investors	It was felt that there was no major change in the report but it was noted that the investment advisors do attend every other meeting to discuss the portfolio and to answer any queries.

Areas where it was felt the CTC added value over the course of 2018-19 were:

- By funding additional items to support enhanced patient experience and carer experience
- Through the purchase of additional equipment
- By working to support the Trust's strategic priorities
- By providing support to the Charity and staff

Key duties and responsibilities:
As referred to above, the key duties and responsibilities of the CTC are to:

- ensure a robust strategy for the delivery of the Charity aims and objectives;
- champion the Charity and its development, providing leadership both within the Trust and externally;
- provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies.

From a review of the relevant materials, it is considered that the Committee achieved these key duties and responsibilities in a number of ways, examples of which are provided below:

Charity Strategy Updates:
The CTC received regular updates on performance against the Charity Strategy 2017-2020 (approved by the Trust Board in January 2018), enabling the Committee to monitor delivery of the Charity aims and objectives. The update reports include information on Charity performance, key achievements and KPIs.

In December 2018, the CTC was informed that the target of becoming a £3m+ hospital charity was not achieved due to a delay in the recruitment process; however, there was renewed confidence that this would be achieved going forward. As a result, the Committee agreed to extend the target date of March 2020 for the Charity raising £3m to March 2021.

The Committee tracked performance in terms of matters such as staff engagement and running costs. Regarding running costs, the final figure for 2018/19 was 21% for the year – below the target of 25%.

The CTC has taken a keen interest in the development of the Charity's reputation and profile, receiving a demonstration on the new Charity website that was launched in 2019. The CTC members have also been visible leaders and ambassadors to the Charity and encouraged the Trust Board to provide similar appropriate support for the Charity.

Charity Policies
The CTC has played a key role in maintaining oversight of policies relevant to the Charity. At the March 2019 meeting, the Charity considered and endorsed an investment policy in order to facilitate the effective management of the Charity funds, whether these are invested or held as liquid assets, to achieve the objectives of the Charity in the immediate and longer term future in conjunction with the identification and understanding of the risks. The policy detailed investment areas subject to restrictions on an ethical basis and the agreed ranges for each class of asset allocation. At the same meeting, the CTC also considered a policy regarding the management of charitable funds which provide clear guidance on how Charitable Funds were to be manged within the Trust, especially procedures around income and expenditure.

Investment Portfolio
The CTC has continued to receive a regular report from Rathbones (the Charity's Investment Advisors) regarding the performance of the Charity's investment portfolio. Representatives from Rathbones attended two of the four meetings to discuss the portfolio with the Committee and respond to any questions such as regarding the mix of investments and the potential economic outlook.

Divisional Fund Management Reports
The CTC has continued the practice of receiving an annual update from each of the Trust's divisional teams in relation to their charitable funds and charitable activities. The reports provided the Committee with information on what the Divisions have delivered in terms of use of charitable funding and any challenges they have encountered and next steps. The Divisional teams have also continued to provide updates on their work to consolidate their funds and any other relevant matters.

Approvals of Expenditure Over £5,000
At each meeting, the CTC has considered any applications for charitable funds that have been submitted for approval valued at between £5,000 and £500,000. This has enabled the CTC to ensure that applications meet the criteria including that each application provides

added value to staff and patients. In addition, the CTC has reviewed proposals for fundraising campaigns.

In 2018-19 there was improved reporting by the divisional teams and scrutiny by CMT of applications prior to CTC review, leading to better quality decision making at the CTC meetings. However, there were a number of occasions where applications had to be considered by email. It is recommended that the Charity should aim to reduce the number of approvals that are sought by email.

Annual Report and Accounts 2018-19

In September 2018, the CTC received the draft Annual Report and Accounts for 2018/19. These were approved by the CTC by correspondence and approved by the Trust Board in November 2018.

Mount Vernon Cancer Centre – Clinical Advisory Group Review

It is recognised that the recommendation of the specialist commissioners' review of the Mount Vernon Cancer Centre that the service is transferred to a tertiary provider would have a significant impact on the work of the Charity. This will need to be monitored at CTC meetings over the course of 2019/20.

Review of Terms of Reference

A review of the Terms of Reference has identified some duties where further work can be undertaken. Theses duties are:

- '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'

It is recommended that work is undertaken to strengthen compliance with these duties during 2019/20. Regarding the second duty listed above, whilst the Audit Committee do receive reports from the Charity's External Auditors regarding the Charity's Annual Report and Accounts, compliance with this aspect of the CTC's terms of reference could be strengthened by ensuring that the proposed review of the Charity governance is also considered by the Trust's Audit Committee.

Conclusion

The Charity Trustee Committee undertook its role effectively in 2018-19, but it is recognised that there are areas where further improvements can be made and that the broader context in which the Charity operates is liable to change in the not too distant future.

In light of this, the following recommendations are made:

- To aim to reduce the number of approvals that are sought by email.
- To undertake a review of the Charity governance to ensure the CTC remains in line with Charity Commission guidance.
- To ensure that the Committee is kept abreast of pertinent developments regarding the transfer of Mount Vernon Cancer Centre.

The CTC is asked to recommend the annual review and the revised terms of reference (which have been reviewed and minor changes proposed – see Appendix 1) for approval by the Trust Board.

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;
- provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies;
- champion the Charity and its development, providing leadership both within the Trust and externally.

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 Trustee Committee is authorised to:

- investigate any activity within its Terms of Reference;
- 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 Strategy
- ~~Director of Finance~~ Financial Controller / Finance representative
- Director of Nursing / Deputy Director of Nursing

In attendance:

- Head of Charity
- Charity Financial Accountant
- Financial Controller
- Associate Director of Corporate Governance / Trust Secretary
- ~~Head of Engagement~~
- additional attendees selected by the Committee as deemed necessary to fulfil its function, including the Charity's Independent Investment Advisor at least annually~~, Trust Financial Controller 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~~ three members must be present, of which one must be a Non-Executive Director and one must be an Executive Director or their nominated representative.

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 review and recommend the Charity Strategy for approval by the Corporate Trustee,
- 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 Trust's 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 between £5,000 and £500,000:
    - 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 Associate Director of Corporate Governance or Trust 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.

Reviewed September 2019

Report to the Audit Committee

EAST AND NORTH HERTFORDSHIRE NHS TRUST CHARITABLE FUND

Audit Completion Report: Year ended 31 March 2019

IDEAS | PEOPLE | TRUST

BDO

CONTENTS

WELCOME
Introduction

We have pleasure in presenting our Audit Completion Report to the Audit Committee. This report is an integral part of our communication strategy with you, a strategy which is designed to ensure effective two way communication throughout the audit process with those charged with governance.

It summarises the results of completing the planned audit approach for the year ended 31 March 2019, specific audit findings and areas requiring further discussion and/or the attention of the Audit Committee. At the completion stage of the audit it is essential that we engage with the Audit Committee on the results of our audit of the financial statements comprising: audit work on key risk areas, including significant estimates and judgements made by management, critical accounting policies, any significant deficiencies in internal controls, and the presentation and disclosure in the financial statements.

We look forward to discussing these matters with you at the Audit Committee on 28 October 2019 and to receiving your input.

In the meantime if you would like to discuss any aspects in advance of the meeting we would be happy to do so.

We would also like to take this opportunity to thank management and staff for the co-operation and assistance provided during the audit.

David Eagles, Partner
for and on behalf of BDO LLP
21 October 2019

David Eagles
Engagement lead

t: 01473 320728
m: 07967 203431
e: David.Eagles@bdo.co.uk

Ross Beard
Project Manager

t: 01473 320785
m: 07966 282745
e: Ross.Beard@bdo.co.uk

OVERVIEW
Executive summary

This summary provides an overview of the audit matters that we believe are important to the Audit Committee in reviewing the results of the audit of the financial statements of the East and North Hertfordshire NHS Trust Charitable Fund ('the Charity') for the year ended 31 March 2019.

It is also intended to promote effective communication and discussion and to ensure that the results of the audit appropriately incorporate input from those charged with governance.

Overview

Our audit work is substantially complete and, subject to the successful resolution of outstanding matters, we anticipate issuing our opinion on the financial statements for the year ended 31 March 2019 in line with the agreed timetable.

Outstanding matters are listed on page 24 in the appendices.

There were no significant changes to the planned audit approach and no additional significant audit risks have been identified.

No restrictions were placed on our work.

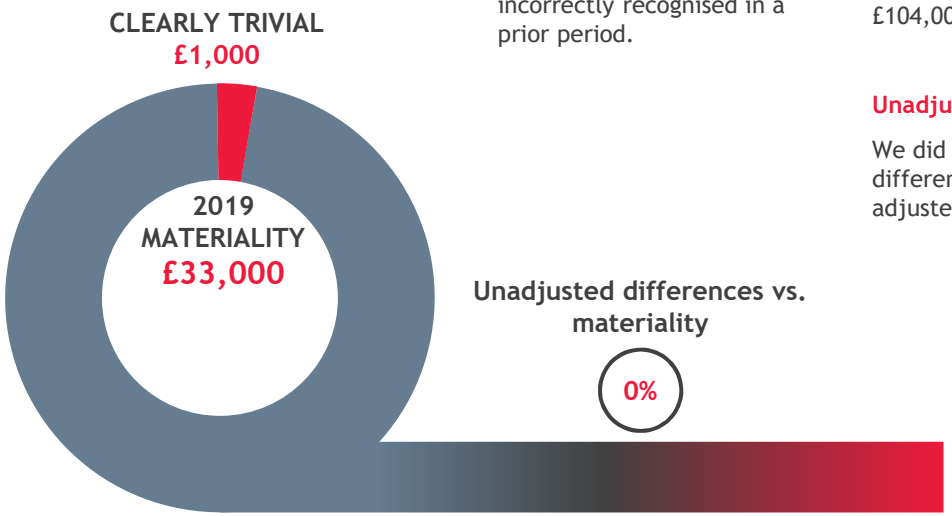
Audit report

We anticipate issuing an unmodified audit opinion on the financial statements.

THE NUMBERS
Executive summary

Final materiality

Final materiality was determined based on 2% of average gross income for the 3 reporting periods since 2016/17.



Material misstatements

Our audit identified the following material misstatements:

- Legacy income of £60,000 erroneously recognised in the current year.
- Legacy income of £163,500 incorrectly recognised in a previous which needed to be corrected as a prior period adjustment.
- Accrued income balance overstated by £111,208 in respect of legacy income incorrectly recognised in a prior period.
- Materially incorrect split between restricted and unrestricted income and expenditure throughout statements and notes.
- Material misclassifications within income note and inconsistency between note and Statement of Financial Activities (SOFA).

Management has amended the financial statements for these issues, which has decreased the net expenditure on the SOFA by £104,000.

Unadjusted audit differences

We did not identify any audit differences that have not been adjusted.

OTHER MATTERS
Executive summary

Financial reporting

- We have not identified any non-compliance with accounting policies or the applicable accounting framework.
- No significant accounting policy changes have been identified impacting the current year.
- The Trustee's Annual Report is consistent with the financial statements and knowledge acquired in the course of the audit.

Other matters that require discussion or confirmation

- Confirmation on fraud, contingent liabilities and subsequent events.
- Control deficiencies in relation to legacy income recognition and financial statement preparation.
- Letter of Representation.

Independence

We confirm that the firm and its partners and staff involved in the audit remain independent of the Charity in accordance with the FRC's Ethical Standard.

AUDIT RISKS OVERVIEW

As identified in our Audit Plan dated 18 February 2019 we assessed the following matters as being the most significant risks of material misstatement in the financial statements. The below risks include those risks which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit and the direction of the efforts of the engagement team.

Audit Risk	Risk Rating	Significant Management Estimates or Judgement	Use of Experts Required	Error Identified	Significant Control Findings	Discussion points / Letter of Representation
Management override of controls	Significant	Yes	No	No	No	No
Revenue recognition	Significant	Yes	No	Yes	Yes	No

Areas requiring your attention

MANAGEMENT OVERRIDE OF CONTROLS

ISA (UK) 240 presumes that management is in a unique position to perpetrate fraud.

Significant risk	■
Normal risk	
Significant management judgement	■
Use of experts	
Unadjusted error	
Adjusted error	
Additional disclosure required	
Significant control findings to be reported	
Letter of representation point	

Risk description

ISA (UK) 240 - The auditor's responsibilities relating to fraud in an audit of financial statements requires us to presume that the risk of management override of controls is present and significant in all entities.

Work performed

We carried out the following planned audit procedures:

- Tested the appropriateness of journal entries recorded in the general ledger and other adjustments made in the preparation of the financial statements.
- Reviewed accounting estimates and judgements applied by management in the financial statements to assess their appropriateness and the existence of any systematic bias.
- Reviewed for any significant transactions that are outside the normal course of business for the entity or that otherwise appear to be unusual to obtain an understanding of the business rationale of any such transactions.

Results and conclusion

Our audit did not identify any evidence of systematic bias or management override in the processing of journals entries and other adjustments, and making of significant accounting estimates.

We have not identified any unusual transactions or transactions that are outside the normal course of business for the Charity.

REVENUE RECOGNITION

Under auditing standards there is a presumption that income recognition presents a fraud risk.

Significant risk
Normal risk
Significant management judgement
Use of experts
Unadjusted error
Adjusted error
Additional disclosure required
Significant control findings to be reported
Letter of representation point

Risk description

Under International Standard on Auditing 240 "The Auditor's responsibility to consider fraud in an audit of financial statements" there is a presumption that income recognition presents a fraud risk.

This risk may arise from the use of inappropriate accounting policies, failure to apply the Charity's stated accounting policies or from an inappropriate use of estimates in calculating revenue. As a consequence our audit work has been designed to focus on these areas.

Work performed

We carried out the following planned audit procedures:

- Carried out audit procedures to update our understanding of the Charity's internal control environment for the significant income streams..
- Substantively tested increased samples of donations, grants, gift aid and legacy income to supporting documentation, to conclude on whether income has been recognised appropriately in the correct accounting period.
- Agreed investment income recognised to third party confirmation.
- Assessed the completeness of income recognised through review of legacy correspondence and Charity Trustee Committee minutes, sample testing from income sheets to the ledger.
- Tested a sample of income received around the year end to ensure it was recorded in the correct year.

Results and conclusions

Sample testing of legacy income identified the following issues related to this risk:

- Entitlement to a legacy of £60,000 recognised as income stems from a will that is being contested. Legacy income recognition criteria are not satisfied and so income is overstated.
- Two legacies recognised in the prior year totalling £163,500 were found to have not satisfied all legacy income recognition criteria. This was highlighted for the key component of £154,500 by receipt of a will copy and correspondence from the executor. The Charity identified the need to reflect this, but recorded correcting entries in the current year draft statements. As this constituted a material misstatement in the prior year accounts, a prior period adjustment was required. Moving this adjustment to the prior year figures increases legacy income in the current year by £163,500.

Sample testing of receivables balances identified the following issues:

- Two legacies recognised as income in 2016/17 totalling £111,208 were found to have not satisfied all legacy income recognition criteria. Respective balances remained on the balance sheet as accrued receivables. In both cases letters have been sent chasing further information, but without responses.
- As these constituted material misstatements in earlier year accounts, an adjustment was required to the earliest period reported in the current year, which was 2017/18. Whilst this did not impact on income in the current year, it is indicative of issues related to the Charity's recognition of legacy income.

Management has amended the financial statements for the above issues.

Audit procedures identified further misstatements related to income, but these relate to misclassification between categories of income and are not linked to this risk. Details have therefore been provided within the Other Matters section on page 10.

OTHER MATTERS

The following are additional significant and other matters arising during the audit which we want to bring to your attention.

Issue	Comment
Fund accounting	The restricted funds note was misstated in respect of £153,000 restricted expenditure recorded erroneously as debits against restricted income. The note was also misstated in respect of a restricted fund with £3,000 reported as restricted income, where this actually represented the movement on the fund. Restricted income of £32,000 and expenditure of £29,000 should have been reported. This note was used to as a basis for the split between restricted and unrestricted income and expenditure in the Statement of Financial Activities (SOFA) and respective income and expenditure notes, which meant these too were misstated. Management has amended the financial statements for the above issues.
Issues with income note	Issues with system reports and working paper formulae led to misclassification between income categories and inconsistency between the income note and SOFA. £220,000 of income reported as grants should have been classified as donations (£203,000) and events (£17,000). A grant for £27,000 was incorrectly classified as a donation. Donations, legacies and grants per the income note totalled £100,000 more than the donations, legacies and grants line in the SOFA.
Recharges from Trust	The Charity is recharged by East and North Hertfordshire NHS Trust for its share of costs incurred by the Trust. The value of the 2018/19 recharge is calculated using outdated information. For instance, apportionment of some staff costs is based on outdated remuneration figures, calculation of overhead costs linked to personnel is based on outdated remuneration figures and staff composition and a recharge for other overhead costs is in-part calculated based on costs for which the Charity is now fully responsible. The recharged amount is agreed between the two entities by virtue of the transaction processed, therefore no misstatement exists. However, we recommend that the recharge is refreshed from 2019/20 using relevant information and that the basis for the recharge is agreed formally between the two entities.
Timeliness of Trustee's Annual Report	Final accounts audit procedures commenced 27 August. However, a draft Annual Report was not received for audit until 3 October. The Annual Report should be made available for audit alongside the financial statements, in line with the agreed timetable for commencing the audit.
Communicating adjustments to auditors	Management identified material misstatements in respect of legacy income recognised in the prior period and adjusted in the current period, which had the impact of reducing legacy income in the current period. The audit team was not notified of the prior period misstatements, or the approach taken to correct them, which impacted on audit materially and risk assessment. Management also identified and adjusted misstatements during the audit process without notifying the auditors. This meant additional work was required late in the audit to reconcile the revised statements and gain assurance over the revised values.

MATTERS REQUIRING ADDITIONAL CONSIDERATION

Fraud

Whilst the directors have ultimate responsibility for prevention and detection of fraud, we are required to obtain reasonable assurance that the financial statements are free from material misstatement, including those arising as a result of fraud. Our audit procedures did not identify any fraud. We will seek confirmation from you whether you are aware of any known, suspected or alleged frauds since we last enquired in our planning letter dated 12 September March 2019.

Related parties

Whilst you are responsible for the completeness of the disclosure of related party transactions in the financial statements, we are also required to consider related party transactions in the context of fraud as they may present greater risk for management override or concealment or fraud.

We did not identify and significant matters in connection with related parties.

Laws and regulations

We have made enquiries of management regarding compliance with laws and regulations and reviewed correspondence with the relevant authorities.

We did not identify any non-compliance with laws and regulations that could have a material impact on the financial statements.

ADJUSTED AUDIT DIFFERENCES: SUMMARY

Summary for the current year

All audit differences identified during the audit were adjusted by management. This decreased the draft net expenditure by £104,000 and decreased net assets by £171,000.

ADJUSTED AUDIT DIFFERENCES: DETAIL

Details for the current year

		Income and expenditure		Statement of Financial Position	
Adjusted audit differences	NET DR/(CR) £'000	DR £'000	(CR) £'000	DR £'000	(CR) £'000
Net expenditure before adjustments	615				
1: Reversal of legacy income where recognition criteria not satisfied due to challenge on will.					
DR Legacy income		60			
CR Accrued income					(60)
2: Reversal of material adjustments made in the current year correcting material legacy errors from the prior year. Adjustments had been incorrectly posted to the current year.					
DR Retained earnings				163	
CR Legacy income			(163)		
3: Prior period adjustments to correct material receivable balances in respect of legacies for which income recognition criteria not satisfied.					
DR Retained Earnings				111	
CR Accrued income					(111)

ADJUSTED AUDIT DIFFERENCES: DETAIL CONTINUED

Details for the current year

	Income and expenditure			Statement of Financial Position	
Adjusted audit differences	NET DR/(CR) £'000	DR £'000	(CR) £'000	DR £'000	(CR) £'000
4: Impact on SOFA of misclassifications between income categories					
DR Donations, legacies and grants		17			
CR Income from other trading activities			(17)		
Total adjusted audit differences		77	(180)	274	(171)
Adjusted net expenditure	511				

REPORTING ON OTHER INFORMATION

We comment below on other reporting required to be considered in arriving at the final content of our audit report:

Matter	Comment
We are required to report on whether the financial and non-financial information in the Trustee's Annual Report is consistent with the financial statements and the knowledge acquired by us in the course of our audit.	We are satisfied that the other information in the Trustee's Annual Report is consistent with the financial statements and our knowledge.

OVERVIEW

Opinion on financial statements

We anticipate issuing an unmodified opinion on the financial statements.

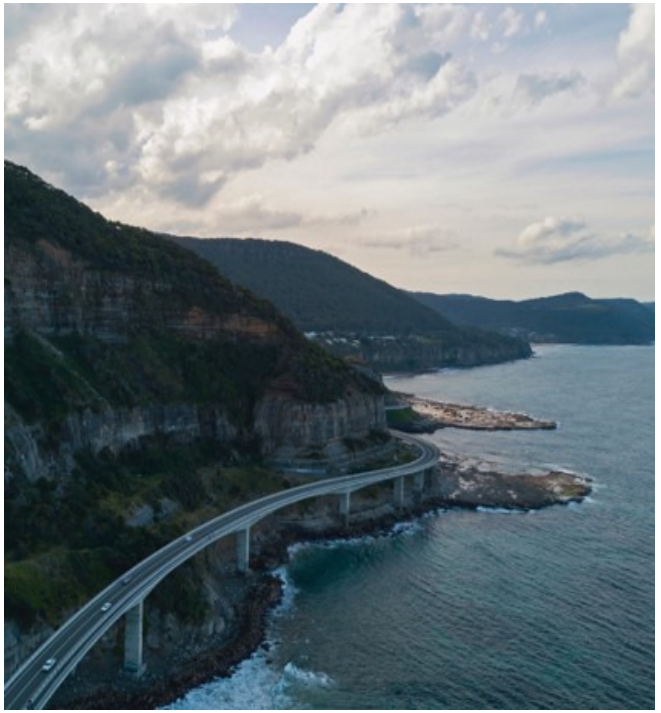
There are no matters that we wish to draw attention to by way of 'emphasis of matter'.

Conclusion relating to going concern

We have nothing to report in respect of the applicability of the going concern basis of accounting or the Charity's ability to continue as a going concern for a period of at least twelve months from the date of approval of the financial statements.

Other information

We have not identified any material misstatements within the 'other information' that would need to be referred to in our report.



SIGNIFICANT DEFICIENCIES

We are required to report to you, in writing, significant deficiencies in internal control that we have identified during the audit. These matters are limited to those which we have concluded are of sufficient importance to merit being reported to the Audit Committee.

As the purpose of the audit is for us to express an opinion on the Charity's financial statements, you will appreciate that our audit cannot necessarily be expected to disclose all matters that may be of interest to you and, as a result, the matters reported may not be the only ones which exist.

As part of our work, we considered internal control relevant to the preparation of the financial statements such that we were able to design appropriate audit procedures. This work was not for the purpose of expressing an opinion on the effectiveness of internal control.

Area	Observation & implication	Recommendation	Management response
Legacy income recognition	A number of misstatements were identified in respect of legacy income where recognition criteria were not satisfied. This demonstrates a lack of control over the accuracy and existence of legacy income reported.	On preparation of the financial statements, all legacies should be reviewed against the legacy income recognition criteria prescribed by the SORP. This review should include consideration of information received after the balance sheet date, which may identify adjusting events occurring after the end of the reporting period as defined by the SORP.	Agreed. Legacy income will be recognised in accordance with the guidance provided in the SORP
Financial statement reconciliation to general ledger	Parts of the financial statements and related notes were prepared using reports/working papers outside of the ledger without ensuring that the output was consistent with the ledger. This led to material misstatement.	Preparation of the financial statements and related notes should be driven by the general ledger. Where necessary to use reports/working papers for further analysis, the output should be reconciled back to the general ledger.	Agreed. This relates to system reports not agreeing back to the general ledger. We will work with Harlequin to ensure system reports reconcile back to the general ledger.
Financial statement review	We identified material errors that should have been identified by management through analytical quality review checks. For instance, total income per the disclosure note was materially inconsistent with the respective value in the SOFA and a highly material annual increase in grant income was indicative of material overstatement.	Prior to submitting the financial statements for audit, management should complete a review that includes: - Checks for consistency throughout the document - Analysis of reported figures against prior year/expected figures.	Agreed.

INDEPENDENCE

Under ISAs (UK) and the FRC's Ethical Standard we are required, as auditors, to confirm our independence.

Under ISAs (UK) and the FRC's Ethical Standard, we are required as auditors to confirm our independence.

We have embedded the requirements of the Standards in our methodologies, tools and internal training programmes. Our internal procedures require that audit engagement partners are made aware of any matters which may reasonably be thought to bear on the integrity, objectivity or independence of the firm, the members of the engagement team or others who are in a position to influence the outcome of the engagement. This document considers such matters in the context of our audit for the year ended 31 March 2019.

We have not identified any relationships or threats that may reasonably be thought to bear on our objectivity and independence.

We confirm that the firm, the engagement team and other partners, directors, senior managers and managers conducting the audit comply with relevant ethical requirements including the FRC's Ethical Standard or the IESBA Code of Ethics as appropriate and are independent of the Charity.

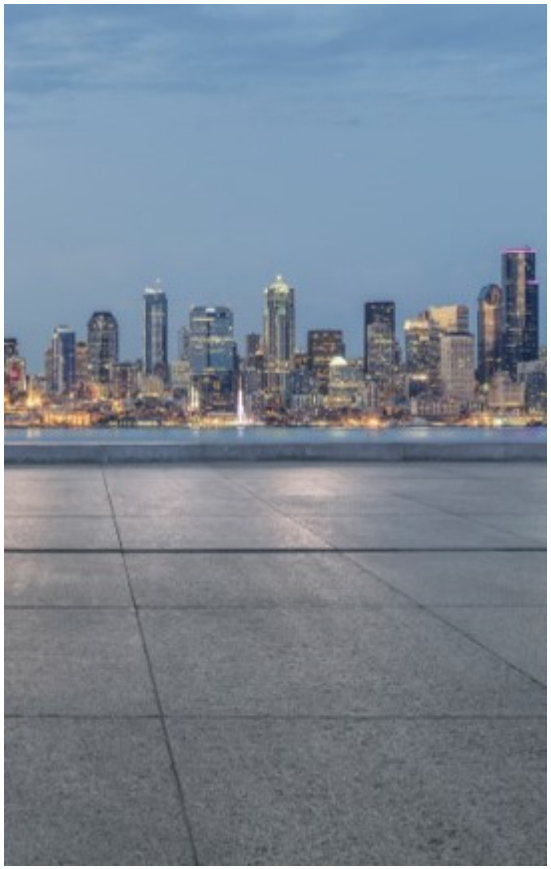
Should you have any comments or queries regarding any independence matters we would welcome their discussion in more detail.

FEES

Fees summary

	2018/19	2017/18
	£	£
Audit fee		
• Financial statements of the Charity	5,400*	6,000
Total fees	**5,400**	**6,000**

* - additional work over and above that planned has been necessary and we will need to discuss and agree additional fees to cover this.



APPENDICES CONTENTS

RESPONSIBILITIES AND REPORTING

Responsibilities and reporting

Our responsibilities and reporting

We are responsible for performing our audit under International Standards on Auditing (UK) to form and express an opinion on your financial statements. We report our opinion on the financial statements to the Trustee of the Charity.

We read and consider the 'other information' contained in the Trustee's Annual Report. We will consider whether there is a material inconsistency between the other information and the financial statements or other information and our knowledge obtained during the audit.

What we don't report

Our audit is not designed to identify all matters that may be relevant to the Audit Committee and cannot be expected to identify all matters that may be of interest to you and, as a result, the matters reported may not be the only ones which exist.

ADDITIONAL MATTERS WE ARE REQUIRED TO REPORT

	Issue	Comments
1	Significant difficulties encountered during the audit.	No exceptions to note.
2	Written representations which we seek.	We enclose a copy of our draft representation letter.
3	Any fraud or suspected fraud issues.	No exceptions to note.
4	Any suspected non-compliance with laws or regulations.	No exceptions to note.
5	Significant matters in connection with related parties.	No exceptions to note.

COMMUNICATION AND REPORTS ISSUED

Those Charged with Governance (TCWG)

References in this report to Those Charged With Governance are to the Trustees of the Charity as a whole. For the purposes of our communication with those charged with governance you have agreed we will communicate primarily with the Audit Committee of the Charity's Corporate Trustee.

Communication, meetings and feedback

We request feedback from you on our planning and completion report to promote two way communication throughout the audit process and to ensure that all risks are identified and considered; and at completion that the results of the audit are appropriately considered.

We have met with management throughout the audit process. We have issued regular updates driving the audit process with clear and timely communication, bringing in the right resource and experience to ensure efficient and timely resolution of issues.

Communication	Date (to be) communicated	To whom
Audit Planning Report	28 October 2019	Audit Committee
Audit Completion Report	28 October 2019	Audit Committee

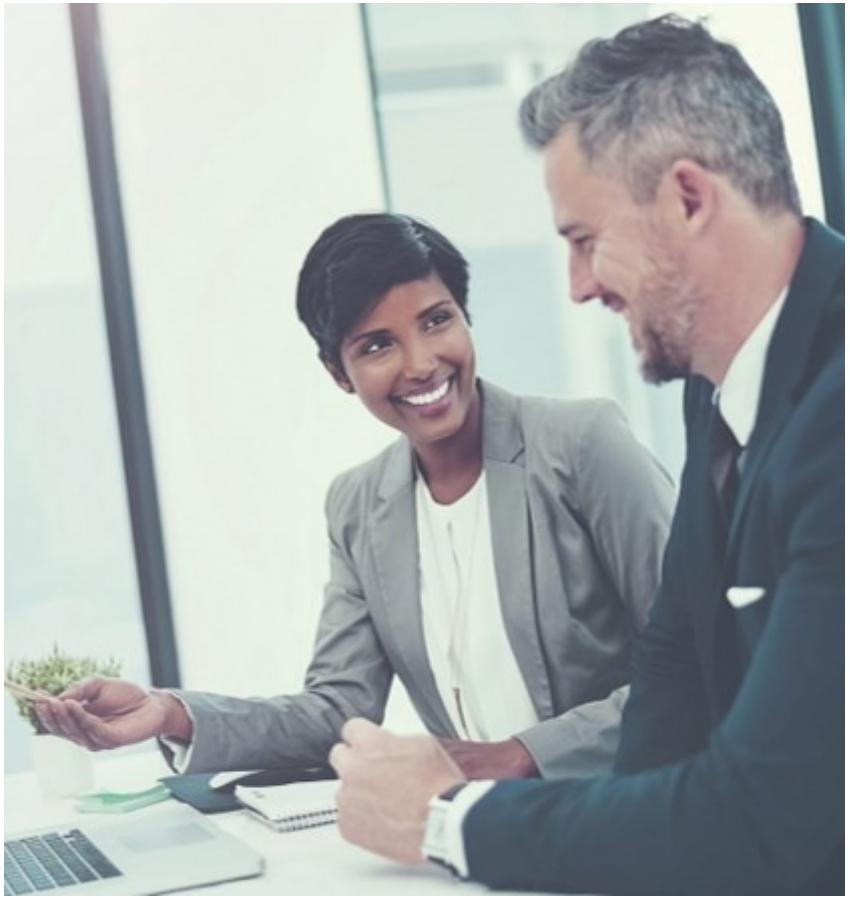
OUTSTANDING MATTERS

We have substantially completed our audit work in respect of the financial statements for the year ended 31 March 2019.

The following matters are outstanding at the date of this report. We will update you on their current status at the Audit Committee meeting on 28 October 2019 at which this report is considered:

- Clearing partner review points
- Final review and approval by you of the financial statements
- Letter of representation, as attached on page 26 to be approved and signed

AUDIT QUALITY



BDO is totally committed to audit quality

It is a standing item on the agenda of BDO's Leadership Team who, in conjunction with the Audit Stream Executive (which works to implement strategy and deliver on the audit stream's objectives), monitor the actions required to maintain a high level of audit quality within the audit stream and address findings from external and internal inspections.

BDO welcomes feedback from external bodies and is committed to implementing a necessary actions to address their findings.

We recognise the importance of continually seeking to improve audit quality and enhancing certain areas. Alongside reviews from a number of external reviewers, the AQR (the Financial Reporting Council's Audit Quality Review team), QAD (the ICAEW Quality Assurance Department) and the PCAOB (Public Company Accounting Oversight Board who oversee the audits of US companies), the firm undertakes a thorough annual internal Audit Quality Assurance Review and as member firm of the BDO International network we are also subject to a quality review visit every three years.

We have also implemented additional quality control review processes for all listed and public interest audits.

More details can be found in our Transparency Report at www.bdo.co.uk

Letter of representation

[ENHT Charitable Fund Letter headed paper]

BDO LLP
16 The Havens
Ransomes Europark
Ipswich
IP3 9SJ

Dear Sirs

Financial statements of East and North Hertfordshire NHS Trust Charitable Fund for the year ended 31 March 2019

We confirm that the following representations given to you in connection with your audit of the Charity's financial statements (the 'financial statements') for the year ended 31 March 2019 are made to the best of our knowledge and belief, and after having made appropriate enquiries of other Members of the Board of the Corporate Trustee and officials of the Charity.

We have fulfilled our responsibilities as the Corporate Trustee for the preparation and presentation of the financial statements, and in particular that the financial statements give a true and fair view of the financial position of the Charity as of 31 March 2019 and of its income and expenditure and cash flows for the year then ended in accordance with the applicable financial reporting framework and for making accurate representations to you.

We have provided you with unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence. In addition, all the accounting records of the Charity have been made available to you for the purpose of your audit and all the transactions undertaken by the Charity have been properly reflected and recorded in the accounting records. All other records and related information, including minutes of all management and relevant meetings of the Corporate Trustee, have been made available to you.

Going concern

We have made an assessment of the Charity's ability to continue as a going concern for a period of at least twelve months from the date on which the financial statements were approved for release. As a result of our assessment we consider that the Charity is able to continue to operate as a going concern and that it is appropriate to prepare the financial statements on a going concern basis.

Laws and regulations

In relation to those laws and regulations which provide the legal framework within which the Charity's business is conducted and which are central to our ability to conduct our business, we have disclosed to you all instances of possible non-compliance of which we are aware and all actual or contingent consequences arising from such instances of non-compliance.

Post balance sheet events

Other than those disclosed in the financial statements there have been no events since the balance sheet date which either require changes to be made to the figures included in the financial statements or to be disclosed by way of a note. Should any material events of this type occur, we will advise you accordingly.

Fraud and error

We are responsible for adopting sound accounting policies, designing, implementing and maintaining internal control, to, among other things, help assure the preparation of the financial statements in conformity with generally accepted accounting principles and preventing and detecting fraud and error.

We have considered the risk that the financial statements may be materially misstated due to fraud and have identified no significant risks.

To the best of our knowledge we are not aware of any fraud or suspected fraud involving management or employees. Additionally, we are not aware of any fraud or suspected fraud involving any other party that could materially affect the financial statements.

To the best of our knowledge we are not aware of any allegations of fraud or suspected fraud affecting the financial statements that have been communicated by employees, former employees, analysts, regulators or any other party.

Misstatements

You have not advised us of any unadjusted misstatements in the financial statements or other information in the Annual Report.

Related party transactions

We have disclosed to you the identity of all related parties and all the related party relationships and transactions of which we are aware. We have appropriately accounted for and disclosed such relationships and transactions in accordance with the applicable financial reporting framework.

Carrying value and classification of assets and liabilities

We have no plans or intentions that may materially affect the carrying value or classification of assets or liabilities reflected in the financial statements.

Litigation and claims

We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements and these have been accounted for and disclosed in accordance with the requirements of accounting standards.

Confirmation

We confirm that the above representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, of inspection of supporting documentation) sufficient to satisfy ourselves that we can properly make each of the above representations to you.

We confirm that the financial statements are free of material misstatements, including omissions.

We acknowledge our legal responsibilities regarding disclosure of information to you as auditors and confirm that so far as we are aware, there is no relevant audit information needed by you in connection with preparing your audit report of which you are unaware. Each member of the Corporate Trustee's Audit Committee has taken all the steps that they ought to have taken in order to make themselves aware of any relevant audit information and to establish that you are aware of that information.

Yours faithfully

Signed on behalf of the Corporate Trustee

[TBC] 2019

FOR MORE INFORMATION:

David Eagles
Partner

t: +44(0)1473 320728
m: +44(0)7967 203431
e: David.Eagles@bdo.co.uk

Ross Beard
Audit Manager

t: +44(0)1473 320785
m: +44(0)7966 282745
e: Ross.Beard@bdo.co.uk

East and North Hertfordshire NHS Trust

Chief Executive's Office
Management Corridor
Lister Hospital
Coreys Mill Lane
Stevenage
Herts
SG1 4AB

BDO LLP
16 The Havens
Ransomes Europark
Ipswich
IP3 9SJ

6 November 2019

Dear Sirs

Dear Sirs

Financial statements of East and North Hertfordshire NHS Trust Charitable Fund for the year ended 31 March 2019

We confirm that the following representations given to you in connection with your audit of the Charity's financial statements (the 'financial statements') for the year ended 31 March 2019 are made to the best of our knowledge and belief, and after having made appropriate enquiries of other Members of the Board of the Corporate Trustee and officials of the Charity.

We have fulfilled our responsibilities as the Corporate Trustee for the preparation and presentation of the financial statements, and in particular that the financial statements give a true and fair view of the financial position of the Charity as of 31 March 2019 and of its income and expenditure and cash flows for the year then ended in accordance with the applicable financial reporting framework and for making accurate representations to you.

We have provided you with unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence. In addition, all the accounting records of the Charity have been made available to you for the purpose of your audit and all the transactions undertaken by the Charity have been properly reflected and recorded in the accounting records. All other records and related information, including minutes of all management and relevant meetings of the Corporate Trustee, have been made available to you.

Going concern

We have made an assessment of the Charity's ability to continue as a going concern for a period of at least twelve months from the date on which the financial statements were approved for release. As a result of our assessment we consider that the Charity is able to continue to operate as a going concern and that it is appropriate to prepare the financial statements on a going concern basis.

Laws and regulations

In relation to those laws and regulations which provide the legal framework within which the Charity's business is conducted and which are central to our ability to conduct our business,

we have disclosed to you all instances of possible non-compliance of which we are aware and all actual or contingent consequences arising from such instances of non-compliance.

Post balance sheet events

Other than those disclosed in the financial statements there have been no events since the balance sheet date which either require changes to be made to the figures included in the financial statements or to be disclosed by way of a note. Should any material events of this type occur, we will advise you accordingly.

Fraud and error

We are responsible for adopting sound accounting policies, designing, implementing and maintaining internal control, to, among other things, help assure the preparation of the financial statements in conformity with generally accepted accounting principles and preventing and detecting fraud and error.

We have considered the risk that the financial statements may be materially misstated due to fraud and have identified no significant risks.

To the best of our knowledge we are not aware of any fraud or suspected fraud involving management or employees. Additionally, we are not aware of any fraud or suspected fraud involving any other party that could materially affect the financial statements.

To the best of our knowledge we are not aware of any allegations of fraud or suspected fraud affecting the financial statements that have been communicated by employees, former employees, analysts, regulators or any other party.

Misstatements

You have not advised us of any unadjusted misstatements in the financial statements or other information in the Annual Report.

Related party transactions

We have disclosed to you the identity of all related parties and all the related party relationships and transactions of which we are aware. We have appropriately accounted for and disclosed such relationships and transactions in accordance with the applicable financial reporting framework.

Carrying value and classification of assets and liabilities

We have no plans or intentions that may materially affect the carrying value or classification of assets or liabilities reflected in the financial statements.

Litigation and claims

As far as we are aware, we have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements and these have been accounted for and disclosed in accordance with the requirements of accounting standards.

Confirmation

We confirm that the above representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, of inspection of supporting documentation) sufficient to satisfy ourselves that we can properly make each of the above representations to you.

We confirm that the financial statements are free of material misstatements, including omissions.

We acknowledge our legal responsibilities regarding disclosure of information to you as auditors and confirm that so far as we are aware, there is no relevant audit information needed by you in connection with preparing your audit report of which you are unaware.

Each member of the Corporate Trustee's Audit Committee has taken all the steps that they ought to have taken in order to make themselves aware of any relevant audit information and to establish that you are aware of that information.

Yours faithfully

Signed on behalf of the Corporate Trustee

6 November 2019

East and North Hertfordshire NHS Trust

Agenda Item: 17.3

TRUST BOARD - PUBLIC SESSION – 6 NOVEMBER 2019

Healthcare Worker flu vaccination best practice management checklist

Purpose of report and executive summary (250 words max):		
The vaccination of healthcare workers against seasonal flu is a key action to help protect patients, staff and their families. NHS England and NHS Improvement have asked that all Trusts complete the best practice management checklist for healthcare worker flu vaccination and publish the self-assessment against these measures in their trust board papers before the end of December 2019. This is to provide public assurance via trust boards that suitable and sufficient plans are underway for the organisation to achieve the highest possible level of vaccine coverage this winter and to ensure that all frontline staff are offered the flu vaccine. The plans in place for flu vaccine delivery to frontline staff comply with all best practice categories.		
Action required: For information		
Previously considered by: Executive Committee – 31.10.19		
Director: Chief People Officer	**Presented by:** Chief People Officer	**Author:** Head of Health at Work

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

Does the issue relate to a risk recorded on the Board Assurance Framework? No

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

If the uptake of flu vaccines is not improved there is a greater risk of the spread of influenza to our patients, staff and our community. Reducing patient safety, public health and increasing pressures on services during the winter. There is also a financial implication as there is a CQUIN target to vaccinate 80% of frontline staff.

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

Healthcare Worker flu vaccination best practice management checklist – 24/10/2019

A	Committed leadership	Trusts self-assessment
A1	Board record commitment to achieving the ambition of 100% of frontline healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	Commitment recorded in Flu vaccine evaluation & planning report approved by Finance & performance committee 22nd May 2019.
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers.	Quadrivalent (QIV) flu vaccine ordered.
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt.	Report submitted and approved 22nd May 2019.
A4	Agree on a board champion for flu vaccine.	Board champions - Director of Nursing, Medical Director, Chief People Officer
A5	All board members receive flu vaccination and publicise this.	Pop up flu clinic on first day of campaign in Trust Management corridor with photography present.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives.	All recommended flu team representatives involved in flu campaign evaluation & planning.
A7	Flu team to meet regularly from September 2019	Meetings held throughout Septwith all directorates and communications team.
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published- sponsored by senior clinical leaders & trade unions.	Rationale publicised in meetings, huddles, leaflets & on knowledge centre.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Vaccine clinic schedules publicised in daily news, social media & posters
B3	Board and senior managers having their vaccinations to be publicised.	Pop up flu clinic on first day of campaign in Trust Management corridor with photography present.
B4	Flu vacation programme and access to vaccination on induction programmes.	Vaccine pop up clinics held during induction.
B5	Programme to be publicised on screensavers, posters and social media	Campaign publicised on screensavers, posters & social media.
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups.	Weekly report provided in email to leaders, peer vaccinators & ambassadors, added to knowledge centre and shared in weekly huddle.
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	120 peer vaccinators identified, trained, released and empowered to vaccinate across all clinical teams.
C2	Schedule for easy access drop in clinics agreed	Flu jab centre in the community hub during October. A mobile flu trolley visiting Lister daily. daily pop up clinics at Lister in Oct/Nov, weekly at QEII and 2/3 times a week at MVCC
C3	Schedule for 24 hour mobile vaccinations to be agreed	Early morning, evening and weekend mobile clinics undertaken. Peer vaccinators to cover full 24 hour period.
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Included in Flu evaluation & Planning report approved 22nd May 2019.
D2	Success to be celebrated weekly.	Success celebrated weekly in huddle, daily news and on knowledge centre

East and North Hertfordshire NHS Trust

Agenda Item: 17.4

TRUST BOARD - PUBLIC SESSION – 6 NOVEMBER 2019

Learning from Deaths Report

Purpose of report and executive summary (250 words max): Reducing mortality is one of the Trust's key objectives. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust. It also incorporates information and data mandated under the National Learning from Deaths Programme.		
Action required: For discussion		
Previously considered by: **Mortality Surveillance Committee 21 August 2019** **QSC – 24 September 2019**		
Director: **Medical Director**	**Presented by:** **Medical Director**	**Author:** **Mortality Improvement Lead**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) **No**
Any other risk issues (quality, safety, financial, HR, legal, equality): **Detailed on page 1 of report**

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

SECTION 1

LEARNING FROM DEATHS REPORT SUMMARY

1.1 INTRODUCTION

Reducing mortality is one of the Trust's key objectives for 2017 to 2019. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust. It also incorporates information and data mandated under the National Learning from Deaths Programme.

The time intervals between quarterly reports have been flexed to allow prior approval by the Mortality Surveillance Committee. In view of the irregular time intervals it was proposed that alternate reports follow a reduced format focusing on refreshed data and headline information. As the first shortened version was well received and the length and content more appropriate to the time available to Committee/Board members, while still providing the key information required for assurance purposes, it is proposed that all future reports follow this format.

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

1.2 KEY METRICS

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

Metric	Result
Crude mortality	Crude mortality is 1.10% for the 12 month period to June 2019 compared to 1.37% for the latest 3 years.
HSMR: (data period Apr18 – Mar19)	HSMR for the 12 month period is **93.59** and is statistically **'better than expected'.**
SHMI: (data period Mar18 – Feb19)	Headline SHMI for the 12 month period is **91.94**: **'as expected band 2'.**
HSMR – Peer comparison	E&NH is ranked 5th (out of 15) in the East of England Peer group.

1.3 HEADLINES

- HSMR has remained stable in the 'better than expected' range
- SHMI has reduced significantly but remained in the 'as expected band'
- Sepsis HSMR has reduced further remaining in the better than expected range
- Mortality Review Tool development to commence following purchase of DatixIQ
- Medical Examiners appointed and implementation plans in progress
- Regular on-going mortality monitoring via Mortality Surveillance Committee, Quality and Safety Committee, Board and joint meetings with ENHCCG.

1.4 CURRENT RISKS

Table 2 below summaries key risks identified:

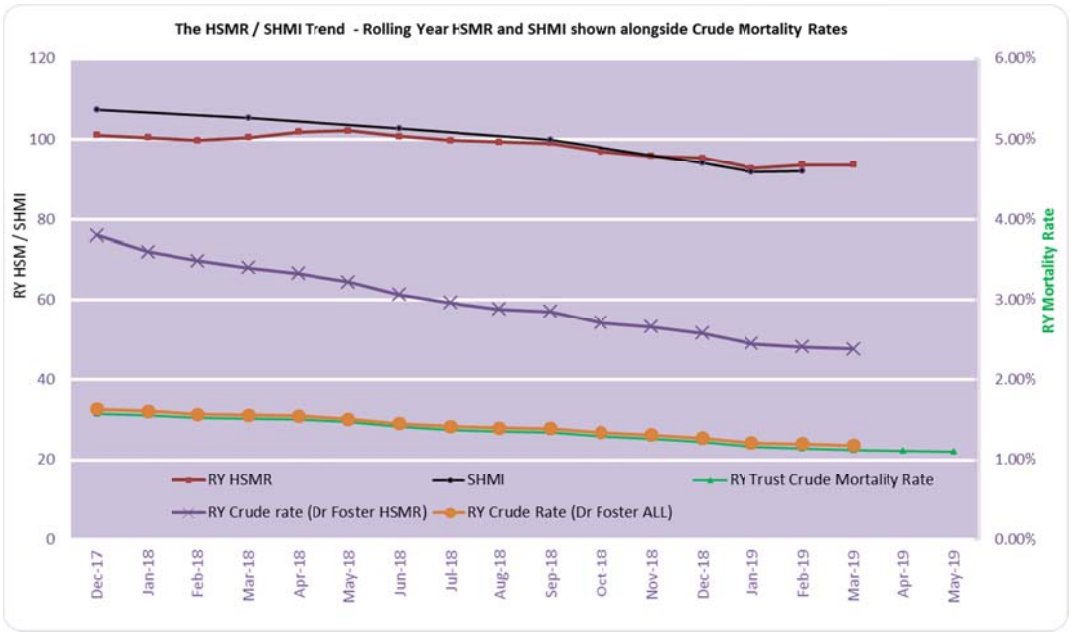
Risks	Report ref (Mitigation)
7 day service/current lack of 7DS Lead	2.5.1
Care bundles/lack of Lead	2.5.2
Medical Examiner Introduction	2.5.3
Mortality management - capacity	3.1
Mortality Review Process – need for significant development of IT tool	3.1
Severe Mental Illness – Identification/flagging of patients	3.2.3

SECTION 2: MORTALITY PERFORMANCE

2.1 KEY METRICS

2.1.1 Trust Rolling 12 Month Overview

Figure 1: Trust Key Mortality Metrics: Latest Rolling 12 Month Position



The chart above shows the Trust's latest Rolling 12 month trend for the three key mortality metrics: Crude mortality, HSMR and SHMI. This shows that all these metrics are continuing on a predominately downward trajectory.

Crude mortality: Dr Foster compares performance of crude mortality and reports that the average national crude in-patient mortality (for Acute, non-specialist trusts, for ordinary admissions excluding day cases) is 1.3% and 1.4% within the region for the twelve months to March 2019. This compares to 1.2% within ENHT. The Trust's locally recorded crude mortality rate, stands at 1.10% for the latest twelve months to June 2019 and has continued on a downward trend.

HSMR: The past 12 months has seen a consistent downward trend in our rolling 12 month HSMR from 101.9 (Mar17-Apr18) to 93.59 for the latest rolling 12 months (Apr18-Mar19), with the last three periods all sitting within the 'better than expected' range. The Trust's position relative to its East of England peers is 5th (out of 15).

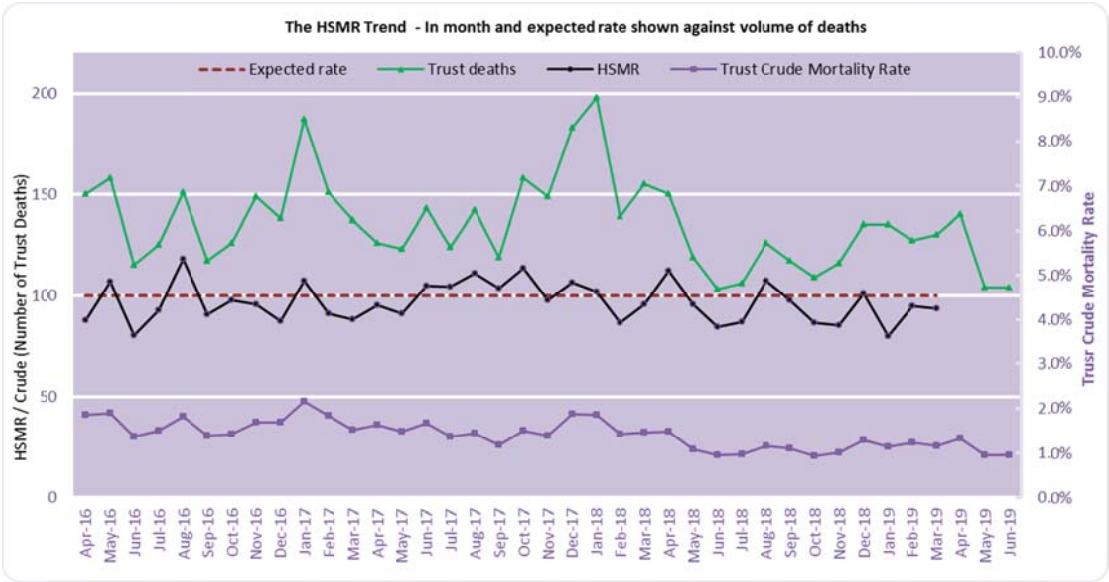
SHMI: The Trust's SHMI currently stands at 91.94 for the rolling 12 months to February 2019 (NHS Digital July 2019 release). This remains in the 'as expected' range. This compares favourably with the 99.90 for rolling 12 months to September 2018 quoted in my previous report, which itself was the first time that the Trust's SHMI has been below 100 since the inception of this metric in 2010.

As previously reported NHS Digital is currently leading a review of SHMI to evaluate potential short and long term changes to improve the indicator. An early change has been the introduction of monthly reporting which was introduced in June 2019.

2.1.2 Trust In-month trend (crude/HSMR)

Figure 2 below provides the latest available in-month position for crude and HSMR mortality rates together with volume of deaths. This shows that while there was some increase in deaths over the winter months, this did not equate to the pronounced spike seen in previous years.

Figure 2: Trust Crude Mortality/HSMR latest in-month trend



The observed number of deaths within the risk model for HSMR is the greatest factor determining the overall score for an organisation which means that crude mortality can be used as a useful predictor of coming HSMR performance.

2.1.3 Divisional HSMR performance

Table 3: Monthly Trust and Divisional HSMR March 2018 to March 2019

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Rolling 12M
Cancer	105.3	88.8	122.9	32.3	102.6	48.4	62.6	79.4	71.9	83.1	49.8	39.2	60.1	70.1
CSS	0.0	0.0	0.0	0.0	0.0	0.0	448.9	0.0	0.0	0.0	0.0	0.0	0.0	40.3
Medicine	99.1	112.3	95.9	94.6	86.7	113.6	96.1	87.0	91.8	105.5	81.1	98.9	99.9	96.9
Surgery	48.8	119.9	89.8	77.4	86.9	104.3	123.3	90.5	58.9	85.0	92.6	96.4	71.6	91.2
Women & Children	0.0	126.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	109.0	0.0	19.2
Trust	**93.9**	**111.3**	**96.2**	**84.2**	**86.9**	**107.3**	**97.7**	**86.5**	**85.2**	**101.1**	**79.5**	**94.8**	**93.5**	**93.6**

Source: Dr Foster Healthcare Intelligence Portal

Table 3 shows Trust and Divisional monthly HSMR performance RAG rated against internal targets for the latest rolling 12 month period to March 2019. The Rolling 12 month position for Medicine shows an amber rating with an HSMR of 96.9. This represents a marginal increase from the last reported HSMR for the twelve months to December 2018 of 96.2.

2.2 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 below compares HSMR/SMR with Length of Stay and Readmissions within 28 days. Since Readmissions data is available 3 months in arrears of HSMR, all metrics have been provided up to that date for comparative purposes.

HSMR mortality for the period is within the 'as expected' band, while Length of stay has remained consistently below the expected levels, meaning that overall we discharge patients sooner than expected for our case mix. In this reporting period while the overall Trust figure for readmissions is in the 'as expected' band, the Non-Elective rate has slipped into the significantly elevated band.

Table 4: Key Quality Measures January 2018 – December 2018

	Trust Total	Elective	Non-Elective
HSMR	95.3	90.6	95.4
SMR	93.0	94.6	92.9
Length of Stay	88.6	87.0	88.8
Readmissions within 28 days	99.0	91.7	102.5

Source: Dr Foster Healthcare Intelligence Portal

2.3 Mortality Alerts

2.3.1 CQC CUSUM Alerts

As previously reported, in March 2018 the Dr Foster Unit at Imperial College alerted the CQC to the Trust's CUSUM alerts for Septicaemia. In November 2018, following a request for further information, we provided a report to the CQC detailing the findings of our internal investigation. One focus of the investigation was an in-depth review of sepsis coding following the changes to national protocols. This resulted in significant changes being made to realign our coding with our new understanding of the requirements, with supporting training given to ensure a standardised approach moving forward. The anticipated significant reduction in our sepsis HSMR occurred in the January Dr Foster release which saw sepsis HSMR fall to 81.06 (better than expected range).

It is now a year since our HSMR was significantly elevated, with the last six HSMR refreshes all falling within the 'better than expected' range. The latest rolling 12 months to March 2019 currently stands at 62.64, latest SHMI to February 2019 has reduced to 70.75 and is also within the 'better than expected' range. The CQC has continued to monitor the situation via its regular Engagement meetings with the Trust.

2.3.2 HSMR outliers

With regard to HSMR for the latest rolling year to March 2019, there is one diagnostic group attracting significantly higher than expected deaths at the 95% confidence level for relative risk where 6 or more deaths are observed.

Table 5: HSMR Negative Outliers April 2018 to March 2019

	Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths
Biliary tract disease	191.92	15	8	7

Source: Dr Foster Healthcare Intelligence Portal

A closer look at the deaths underpinning this alert has commenced with a coding review, the results of which are awaited.

2.3.3 SHMI outliers

With regard to SHMI for the latest rolling year to February 2019, there are 2 diagnostic groups reporting significantly higher numbers of observed than expected deaths where the calculated numbers of expected deaths is 5 or more.

Table 6: SHMI Negative Outliers March 2018 to February 2019

CCS Group	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths
Diverticulosis and diverticulitis	250.00	25	10	15
Congestive heart failure, nonhypertensive	140.00	105	75	30

Source: Dr Foster Healthcare

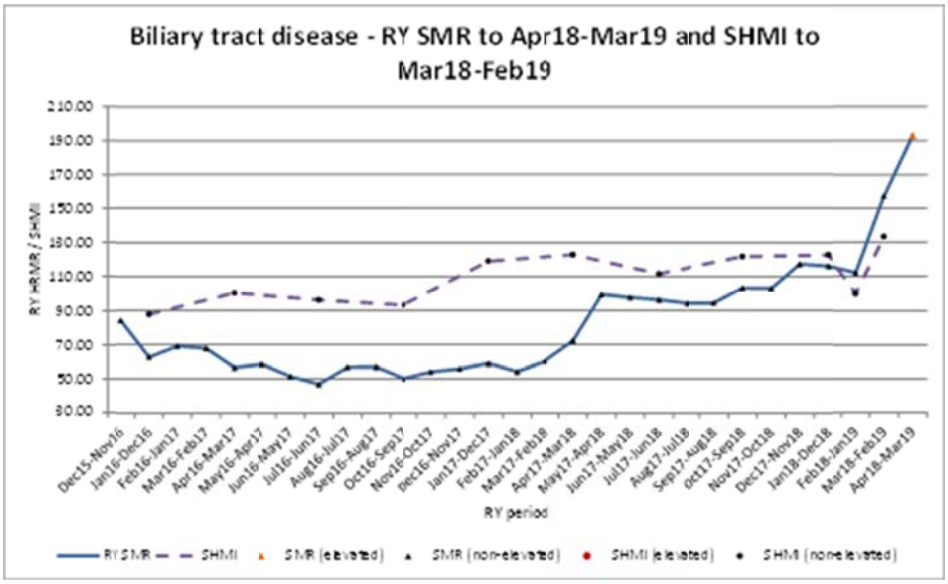
2.4 Specific Actions to Address High Mortality Conditions

Mortality Alerts meetings, chaired by the Medical Director, are now held following Dr Foster monthly refreshes to review new CUSUM alerts and HSMR/SHMI diagnosis group outliers. Agreed actions then feed into the Mortality Surveillance Committee.

The HSMR/SHMI trends of alerting groups are tracked. Investigation usually starts with coding reviews. Where concerns or uncertainty persist Specialty clinical reviews are requested. A watching brief is maintained until there is assurance regarding performance. When the number of deaths is very small, or the diagnosis group consists of a number of sub categories, the situation may be monitored before action is taken.

2.4.1 Biliary Tract Disease

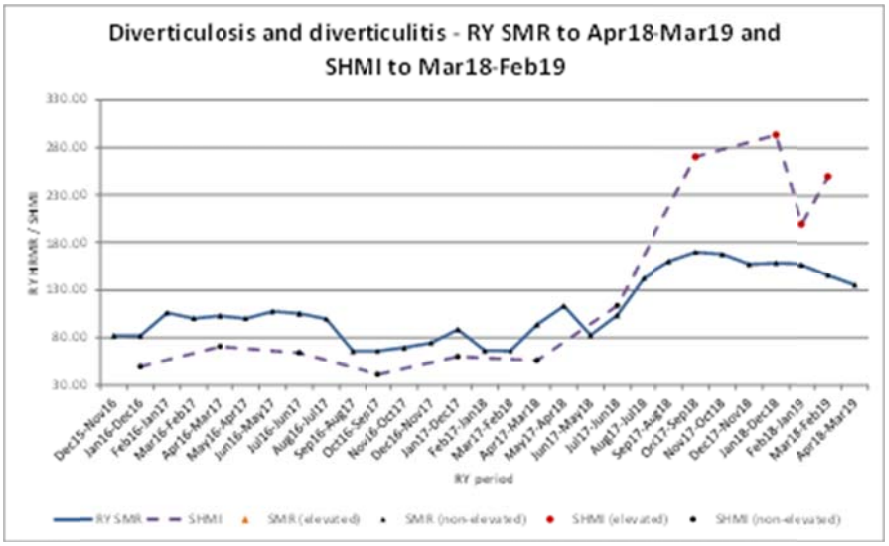
Figure 3: Biliary Tract Disease HSMR/SHMI latest rolling 12 month trend



As detailed in 2.3.2 above, a closer look at this outlier has commenced with a coding review.

2.4.2 Diverticulosis & Diverticulitis

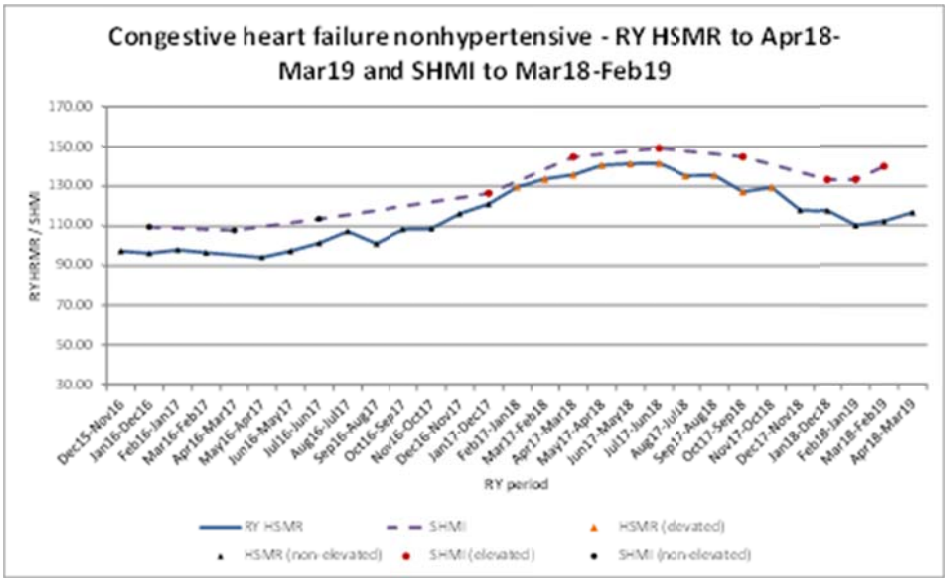
Figure 4: Diverticulosis and diverticulitis HSMR/SHMI latest rolling 12 month trend



This SHMI alert showed a significant, sharp increase (relatively small numbers of deaths are involved). The latest releases for the rolling 12 months to January and February 2019 showed fluctuations in SHMI, which has remained significantly elevated. While a Coding review revealed a few minor coding discrepancies a Clinician review did not give rise to any clinical concerns. While SHMI remains elevated the diagnosis group will continue to be monitored in Mortality Alerts meetings.

2.4.3 Congestive Heart Failure

Figure 5: Congestive Heart Failure HSMR/SHMI latest rolling 12 month trend



While HSMR for Congestive heart failure non-hypertensive has returned to the 'as expected' range, SHMI has remained elevated, with the rate for the rolling 12 months to February 2019 standing at 140.0. A clinical review of a sample of deaths underpinning the deaths was undertaken.

Of the 22 deaths reviewed the following key points were observed:

- 11: Heart failure was not the main condition treated/cause of death
- 6: possible heart failure
- 5: definitely heart failure
- Heart Failure nurses were not always being involved in the patient care.

Due to the fact that in 50% of the reviewed deaths heart failure was not an appropriate diagnosis, and may not have been in a significant number of the remaining deaths, together with some concerns regarding appropriate specialist nurse care, it was decided that further monitoring should be undertaken. It was agreed that for the time being all new deaths with a primary diagnosis of heart failure should be subject to a joint coding/clinician discussion/review at the relevant weekly MDT meetings. Findings from this process will be provided to the Mortality Alerts meeting, and Mortality Surveillance Committee, for further review, to ascertain if additional remedial action is required.

2.4.4 Summary report of recent outliers

While HSMR and/or SHMI have recently been reported to have been significantly elevated or of some concern, the mortality rates for the following outliers have now returned to the 'as expected' range, with the exception of Sepsis which currently sits within the 'better than expected' range. For assurance purposes, brief details have been provided in table 7 below regarding the outcome of our monitoring activity.

Table 7: Recently elevated diagnosis groups update

Diagnosis group	HSMR R12m-Mar19	SHMI R12m-Feb19	Investigation summary
Sepsis	62.70	70.75	Investigation following CQC alert led to changes in the interpretation of coding protocols which have been reflected in significant reductions to both HSMR/SHMI.
Pneumonia	103.42	110.09	Joint coding/clinical review of 36 cases. 20 were found to have been coded incorrectly. The poor clinical awareness was discussed with the Respiratory Lead and a Coding presentation to the respiratory physicians was agreed. Significant improvements have since been seen in mortality rates. Neither HSMR nor SHMI are currently alerting.
Coronary atherosclerosis	188.62	150.00	The clinical review concluded that of the sample of 12 deaths reviewed all had been managed appropriately; 7 were OOHCA; 2 were incorrectly coded.
Stroke	99.60	106.45	As it was SHMI that had alerted, a sample of 20 deaths of patients who had died within 30 days of discharge were considered. Coding errors were discovered in 4 cases. The review did not highlight clinical concerns relating to the deaths that occurred in the Community following discharge from hospital.
Chronic renal failure	82.51	*Not available	A joint coding/clinical review was undertaken of 13 deaths. 12 of the deaths were shown to be incorrectly coded. The findings were presented back to the Renal team and it was agreed that moving forward simultaneous mortality/coding reviews should commence. The review highlighted that junior doctors were not liaising sufficiently with consultants regarding the COD for death certificate and while there was strict oversight of these

			patients in Renal, this cohort were often not on Renal wards. It is anticipated that the introduction of the Medical Examiner role should deal with such issues.
Infective arthritis and osteomyelitis		*Not available	The coding review of deaths underpinning the alert revealed that these were complex patients which often made coding of the primary diagnosis challenging. No coding concerns were raised and further clinical review was not considered to be warranted.
Fractured neck of femur	90.42	100.30	Following a predominantly downward trend in deaths over recent years, there was a spike in deaths in 2018. This was sufficient for the Trust to receive notification from the National Hip Fracture Database (NHFD) regarding mortality, although the Trust was not an official outlier. While neither HSMR nor SHMI has been significantly elevated, the Mortality Surveillance Committee asked that the diagnosis group be monitored until it was clear that the situation had stabilised.

* Since January 2019 Dr Foster's Mortality Comparator has not yet updated to reflect the new monthly reporting of SHMI. While a short report has been provided which indicates diagnosis groups which are significantly elevated, for other data we are reliant on NHS Digital. However, NHS Digital does not report on diagnosis groups where there are five or less deaths for the purpose of disclosure control. For this reason rolling 12 month SHMI for these two diagnosis groups is not currently available.

2.5 Associated Trust Initiatives

2.5.1 Seven Day Services

The Trust continues to work towards 7 day working and fully achieving the Keogh standards set out in the report NHS Services, Seven Days A Week. ENHT was confirmed as being in the tranche of trusts tasked with achieving compliance against the four prioritised standards by the end of March 2018. These 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 target of compliance with the four prioritised standards by the end of March 2018 was not achieved. Focus on this work has been hampered by the absence of a 7 Day Services Lead. Discussions are taking place with the Deputy Chief Operating Officer regarding responsibility for oversight of this important work.

2.5.2 Care Bundles

While our work to improve the use of available care bundles is strongly supported by the CCG via the Mortality Review Group, as previously reported, progress has been hampered by resource constraints. It is intended that focus on care bundles will be strengthened by incorporation of the work into wider quality improvement initiatives together with the anticipated appointment of an Associate Medical Director with responsibility for reducing avoidable variation. It had been intended that this post would incorporate clinical leadership of Mortality, Care Bundles and 7 Day Services. To date as it has proved challenging to attract appropriate candidates for the role, the scope is being reconsidered.

2.5.3 Medical Examiner

A team of 8 Medical Examiners has now been recruited from within the Trust's existing consultant body and includes a Lead and Deputy, and multi-disciplinary representation. The Medical Examiner function will sit within Clinical Support Services. The Division is now working with the newly appointed Lead Medical Examiner to scope the requirements for implementation which is intended to take place over Q3/4 2019-20 during the non-statutory implementation phase.

The latest update from NHS Improvement in June 2019 highlighted the need for close collaboration between the Medical Examiner function and Learning from Deaths programme, with Medical Examiners being responsible for flagging cases warranting further review. As plans progress for the migration of the Trust's mortality review process to the Datix iCloud platform it will be imperative that the required interaction between the processes in taken into account.

2.5.4 Coding/Data Quality

The heads of both Coding and Data Quality continue to drive forward quality improvement initiatives. These are not only of direct significance regarding the provision of better quality information, but are also resulting in greater engagement by Clinicians as confidence in data provided to them increases. The seeds of this cultural shift should support future improvements.

SECTION 3: LEARNING FROM DEATHS

3.1 Mortality Case Record Review Process and Methodology

The decision to adopt the Datix iCloud platform to support our Clinical Governance framework has now been signed off and the start of implementation development work with Datix is anticipated to commence shortly. This work will include change to both our mortality review content and process.

Although significant changes to both our Learning from Deaths Policy and Mortality Case Note Review Policy are anticipated in the next 12 months, our existing policies have been refreshed to reflect developments to date.

Recruitment of a Manager to support our Mortality Improvement Lead is in its final stages. Once in place the manager's core responsibility will be the day to day management of the mortality review process including administration of ACONs (Areas of Concern).

3.2 Mandated Mortality Information

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

3.2.1 Learning from Deaths Dashboard

The National Quality Board provided a suggested dashboard for the reporting of core mandated information. This is currently being used and is attached at Appendix 1. It should be noted that for cases where Areas of Concern are raised, the current lapse in time between the death and completion of Stages 1, 2 and 3 of the review process, means that the avoidability of death score is often not decided in the same review year. This should be borne in mind when viewing the data contained in the dashboard at Appendix 1, which only details the conclusion details for 2018-19

deaths which can appear to skew the data. In this regard, of particular note, in Q4 three ACONs were concluded relating to a death in 2017/18 where an avoidability of death score of less than 3 was decided, as detailed below.

Table 8: 2017-18 Death: Avoidability Score ≤3

ID	Serious Incident	Avoidability score	Avoidability definition
ACON 283	Yes	2	Strong evidence of avoidability
ACON 296	Yes	2	Strong evidence of avoidability
ACON 328		3	Probably avoidable, more than 50-50

All three cases have been investigated as a Serious Incidents and remedial action plans put in place.

It is intended that the creation of a more useful dashboard will form part of the process developments alluded to in 3.1 above.

As the current dashboard does not cover all the data that the national guidance requires, the additionally mandated detail is provided below.

3.2.2 Learning Disability Deaths

Table 9: Q4 Learning Disability Deaths

	Jan-19	Feb-19	Mar-19
Learning Disability deaths	2	2	2

In Q4 6 deaths occurred of patients with a learning disability. All the deaths have been reported to the national LeDeR programme. Internal mortality reviews did not give rise to concerns in four cases. The remaining two cases have been reviewed by the patient safety team. One has been declared a Serious Incident, and a Root Cause Analysis requested for the second. Outputs of these investigations are awaited.

3.2.3 Severe Mental Illness Deaths

The learning from deaths guidance stipulates that Trusts must have systems in place to flag patients with severe mental health needs so that if they die in an Acute Trust setting their care can be reviewed and reported on. No clear indication was given in the national guidance regarding what definition should be attached to the term ‘severe mental illness’.

Discussion at the March East of England Learning from Deaths Forum, revealed the general uncertainty among acute trusts as to how best to interpret and comply with this requirement. Following discussions with our expert mental health colleagues at Hertfordshire Partnership University NHS Foundation Trust, we are proposing to base our criteria for mortality review on the ‘red flags’ detailed in the national guidance for NHS mental health trusts, which was drawn up by the Royal College of Psychiatrists (RCPsych) in November 2018. Discussions are underway to include a supporting alert on Lorenzo. Additionally, now that clarity has been gained as to which diagnoses should be considered for this cohort of patients, a regular report of deceased patients revealing relevant ICD10 codes is to be requested to ensure that the deaths of this vulnerable cohort of patients are reviewed in line with the Learning from Deaths guidance.

3.2.4 Stillbirth, Children and Maternity Deaths

Q4 statistics are provided below:

Table 10: Q4 Stillbirth, Children and Maternity Deaths

	Jan-19	Feb-19	Mar-19
Stillbirth	0	1	2
Children	0	1	0
Maternity	0	0	0

3.2.5 Serious Incidents involving Deaths

Table 11: Q4 Serious Incidents Involving a Patient Death

Serious Incidents involving the death of a patient	Jan-19	Feb-19	Mar-19
Serious Incidents reported	1	6	6
Serious Incidents – final report approved*	7	8	5

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

Key issues highlighted in the Serious Incidents approved in Q4 included:

- Pressure ulcer under a dressing had not been recognised
- Reliance on clinical support workers to relay changes to skin condition to nurses
- Bed management - transfer to an outlier ward led to delays to haemodialysis
- Sub-optimal management of warfarin reversal then delay in administering Octaplex
- Process deficiencies - pathway for patients requiring a laparotomy; application of sepsis 6; scanning for the acute abdomen
- Learning disability - failure to request support from the LD team; carers left before being asked for baseline information
- Failure of follow up required actions – request for enhanced care support; referral follow-up; test results
- Sub-optimal management of nutrition and hydration needs due to being NBM
- Failure to recognise and escalate a deteriorating patient
- Documentation not used optimally - mouth care bundle; WHO checklist; falls proforma; MCA assessment; waterlow
- Training deficiencies - competency to manage stoma bag; use of WHO checklist
- Lack of clarity over the requirements of Baywatch.

3.2.6 Learning from Complaints

Table 12 below provides detail of the number of complaints received in Q4 that relate to a patient who has died.

Table 12: Q4 Complaints Involving a Patient Death

	Jan-19	Feb-19	Mar-19
Complaints received relating to an in-hospital death	1	2	3

3.2.7 Learning from Inquests

Table 13: Q4 Inquests into a Patient Death

	Jan-19	Feb-19	Mar-19
Requests for a Report to the Coroner	6	4	4
Regulation 28: Report to Prevent Future Deaths	0	0	0

3.2.8 Learning from Mortality Reviews

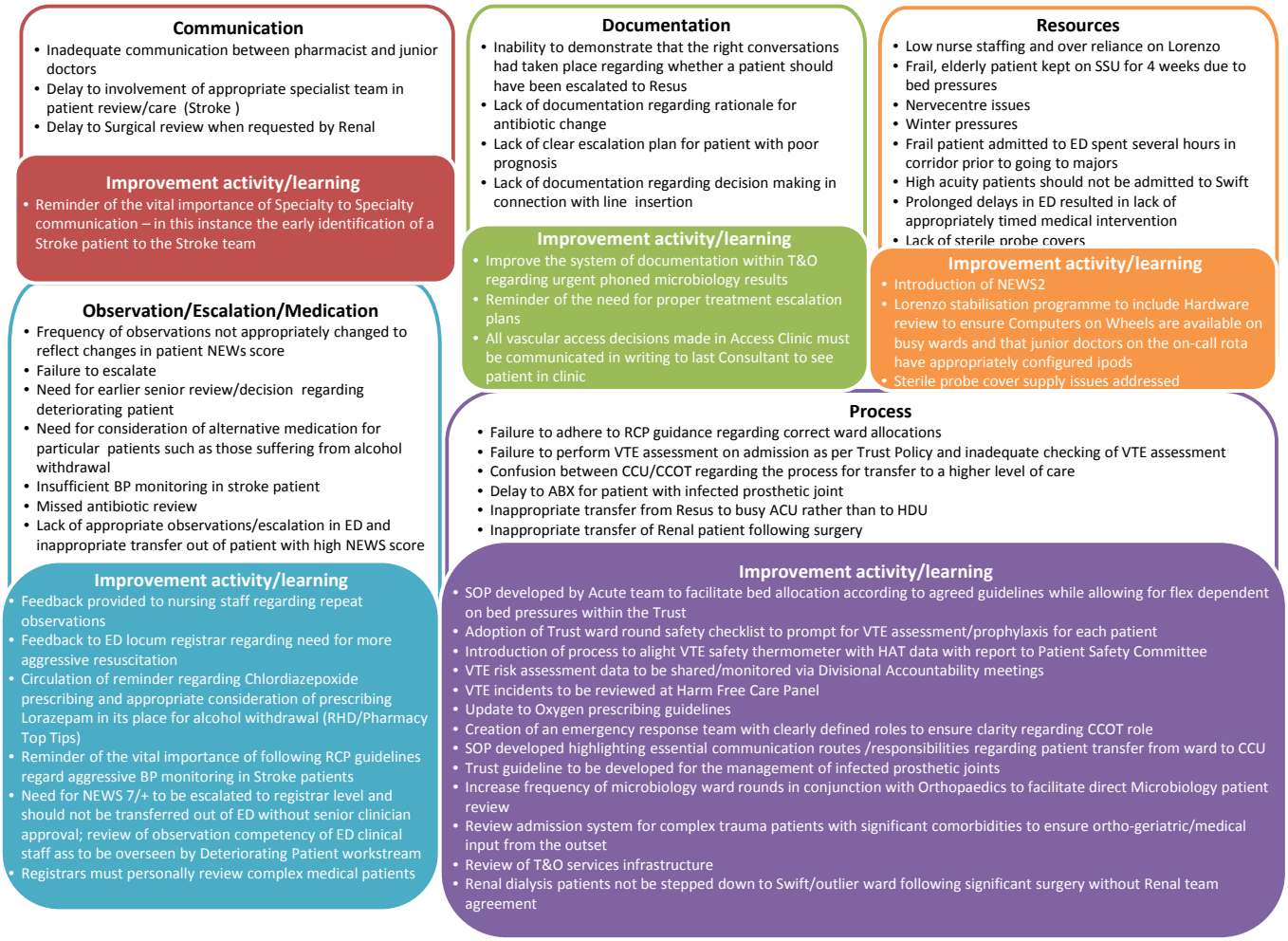
Central to the topics covered at clinical governance Rolling Half Days are cases raised as Areas of Concern (ACONs) as a consequence of mortality case record reviews. The RHD meetings provide a forum for discussion, learning and the creation of appropriate Specialty-specific action plans and represent a key element of the Trust's learning from deaths framework.

In order to ensure all important themes and learning are made available to the Board, the detail provided above in Figure 6 relates to all ACONs concluded in Q4, whether the patient's death occurred in the current or previous year.

Throughout the year emerging themes are shared across the Trust via RHDs. The quarterly information is also shared with the Deteriorating Patient and End of Life work groups. The information will also be used to inform quality improvement initiatives.

Key themes arising from the ACONs which were concluded in Q4 are detailed in Figure 6 below.

Fig 6: ACON Themes: Q4 2018-19



Following the end of 2018-19, a summary of key themes has also been distilled from the quarterly detail. This is provided in figure 7 below:

Fig 7: 2018-19 ACON Key Themes

4.0 OPTIONS/RECOMMENDATIONS

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

Appendix 1: ENHT Learning from Deaths Dashboard March 2019

East and North Hertfordshire NHS Trust: Learning from Deaths Dashboard: December 2018

Department of Health

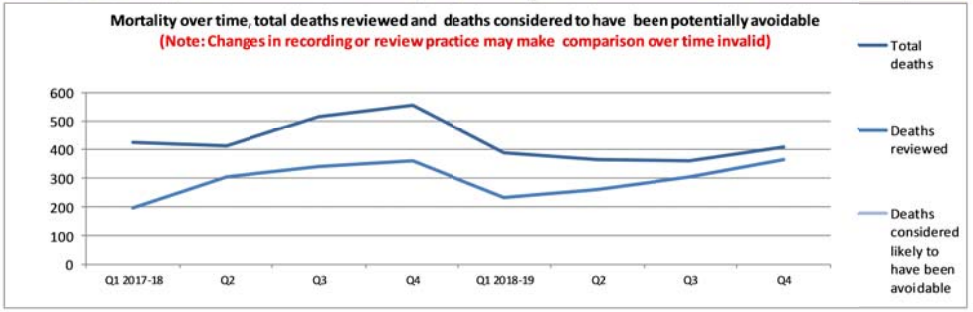
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by East and North Hertfordshire NHS Trust ard is based on the dashboard suggested by the National Quality Board in its Learning from Deaths Guidance published in March 2017. Its purpose is to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Summary of total number of deaths and total number of cases reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
135	129	127	109	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
406	361	363	304	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1518	1904	1161	1199	0	2

Time Series: Start date 2017-18 Q1 End date 2018-19 Q4



Total Deaths Reviewed by RCP Methodology Score

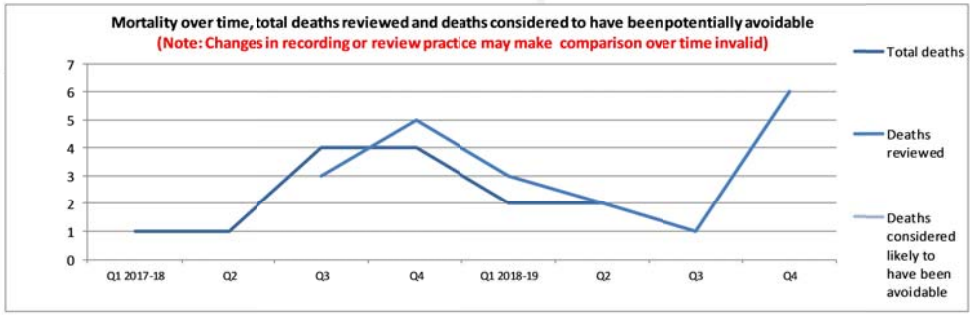
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	121	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD	353	100.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	0.1%	This Year (YTD)	8	0.6%	This Year (YTD)	1303	99.3%

Summary of total number of learning disability deaths and total number reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	2	2	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
6	1	6	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
11	10	12	8	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q4



East and North Hertfordshire NHS Trust

Agenda Item: 17.5

TRUST BOARD - PUBLIC SESSION – 6 NOVEMBER 2019
Nursing, Midwifery and AHP Strategy Progress Report

Purpose of report and executive summary (250 words max): The purpose of the report is to provide details of the progress that has been made in implementing the Nursing, Midwifery and Allied Health Professionals Strategy for 2019-24 which was launched in May 2019.		
Action required: For information		
Previously considered by: QSC – 24 September 2019		
Director: Director of Nursing	**Presented by:** Director of Nursing	**Author:** Director of Nursing and Project Manager – Nursing & Patient Experience

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

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

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

East and North Hertfordshire NHS Trust

Nursing, Midwifery and Allied Health Professionals Strategy 2019-24

Progress report – October 2019

Introduction

#hello my name is…

Rachael Corser

The Nursing, Midwifery and Allied Health Professionals (AHP) Strategy for 2019-24 sets out our vision for nurses, midwives and AHPs for the next five years. It was developed through collaborative working and is aligned to the Trust's Clinical Strategy and Quality Strategy.

The six key priorities identified are:

- Developing and strengthening **leadership**
- Optimising **pathways**
- Valuing **people**
- Inspiring and innovating through **research** and **quality improvement**
- Ensuring **quality and safety**
- **Partnership** working

The Strategy was launched in May 2019. Teams from across the Trust were able to showcase the work they do and learn what the new Strategy will mean for them.

I am delighted to share with you details of the progress that has been made over the last six months.

Rachael Corser
Director of Nursing and Patient Experience

Nursing, Midwifery and AHP Strategy Launch – 7 May 2019

The senior nursing team bake off ….

Developing and strengthening leadership

by:

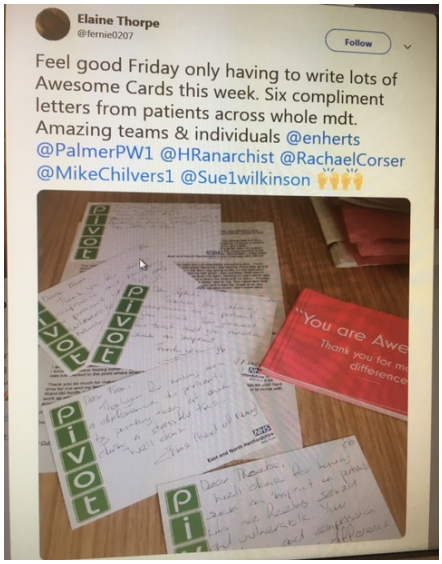
- Nurturing a culture where all staff feel valued.
- Working with Health@Work to reduce staff sickness.
- Creating clear career pathways and learning resources, making it easier for staff to access development opportunities
- Introducing a multi-disciplinary teaching programme for all newly qualified staff.
- Creating programmes that will develop staff trainers and coaches
- Introducing a structured ward leaders programme.
- Making it easier for staff to access senior leaders.
- Encouraging all senior clinical staff to take part in FUNdamental Friday, an initiative that demonstrates excellence in care.

Staff feel valued:

We recognise that our staff continue to provide excellent care to our patients throughout some challenging times. Our annual staff awards for 2019 have been launched and are a fantastic opportunity for us to celebrate the amazing care and compassion shown by our staff and recognise all of their hard work.

The Surgery Division has introduced the ***'You are Awesome'*** cards which are written and given to staff and teams who have gone above and beyond.

These achievements are also celebrated and shared on social media:



Frailty Project

We are proud to be part of the Sustainability and Transformation Partnership frailty project. As part of this work we are providing frailty training to all staff. Our aim is to train 90% of staff in the Emergency Department by the end of October 2019 and for 90% of staff in the Medical Division to be trained by April 2020.

We will be using the Rockwood frailty score to assess all patients aged over 65 attending the Emergency Department. We are working with our Information Technology Team to record the Rockwood score on Nervecentre, our electronic observations system.

Reducing staff sickness:

The Health@Work team provide independent advice to both managers and staff to optimise health at work, reduce sickness absence and prevent work related ill health and injury. They actively encourage staff to look after themselves and offer a wide range of information and advice.

Health@Work promote a range of initiatives via the Daily News which is sent to all staff:

Keep a check on your mental health. The nhs.uk website has a quick and simple quiz you can take called *How have you been feeling lately?*

NHS Mental Health Quiz

The Health@Work service provides support and advice for anyone affected by mental health issues. If you wish to speak to somebody outside the organisation, you can contact the confidential and independent Employee Assistance Programme (EAP) provided by Workplace Options. Their freephone number is 0800 243458.

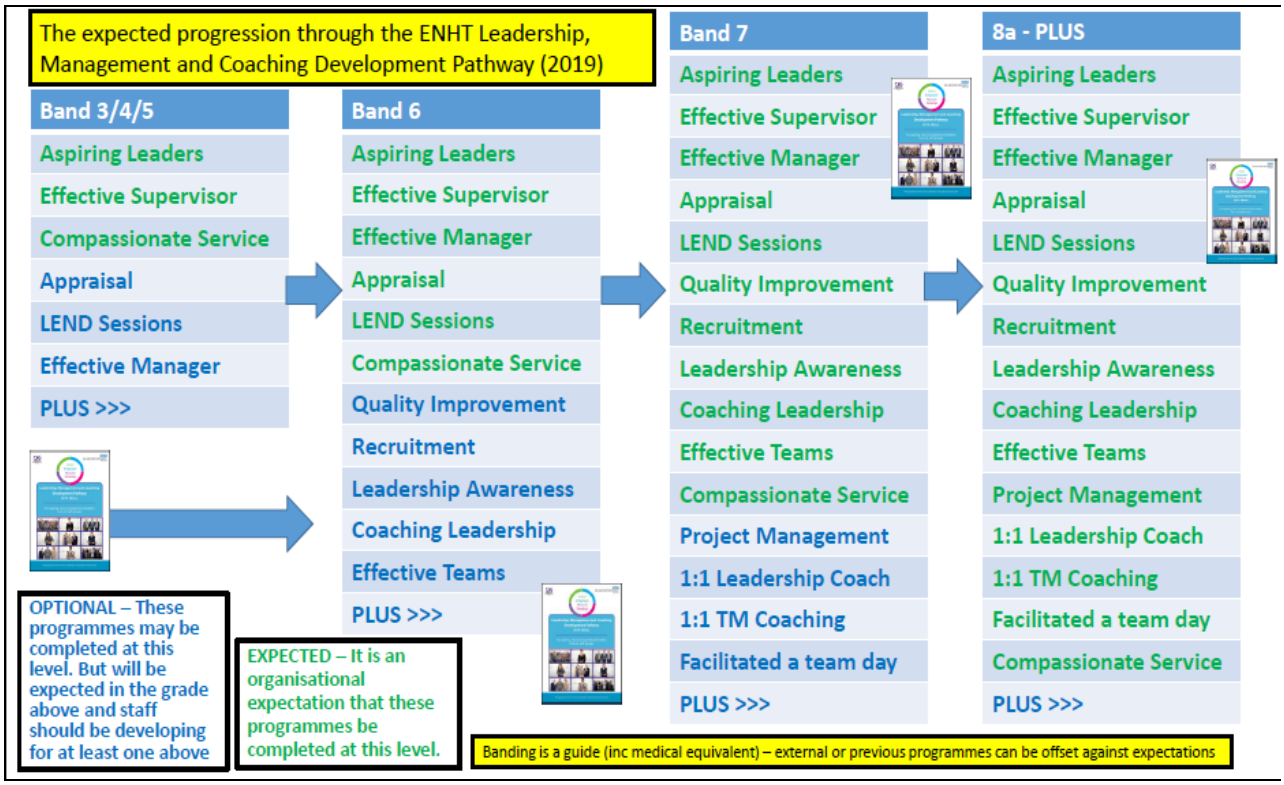
Well-being forum at the Lister

Our Health@Work service has some great advice and support on well-being at work, as well as looking after your mental health. Come and join the Health@Work team today in the Lister's coffee lounge (11.00am to 1.00pm) and talk to them about how you can champion well-being in the workplace, share good practice and explore how to improve the well-being of your team.

Career pathways and learning resources / Develop Staff trainers and coaches:

Our Listen, Empower, Nurture, Develop [LEND] sessions focus on leadership development and this is backed up by a comprehensive leadership development training programme which aims to develop a culture of compassionate leadership. There is a clear expected progression through the ENHT Leadership, Management and Coaching Development Pathway:

FUNdamental Friday's are a set time each week when senior nurses and midwives will focus on clinical work, staff from different wards are buddying up together and looking at their wards with a fresh pair of eyes. This should be a fun and enjoyable way to learn and improve as well as a chance to share all the great things that are happening in the wards and departments.



Leadership, Management Development & Coaching Pathway

Accessing senior leaders / FUNdamental Fridays:

Every Tuesday and Friday mornings we hold a *quality huddle* in the Lister coffee lounge which all senior clinical staff are welcome to join. This is an opportunity for the senior nursing team to share information with the team and for everyone to raise questions and share good practice.

Nick Carver joins the team on 6B on FUNdamental Friday

Multi-disciplinary teaching programme:

The senior nursing team are working collaboratively with the HR leadership team to develop an education framework.

Clinical Leadership Programme:

20 ward/department managers have been recruited to the Royal College of Nursing (RCN) Clinical Leadership programme commencing September 2019. This programme underpins our vision and aspirations for quality improvement and will be facilitated by three RCN trained facilitators: our Associate Director Quality and Safety, Quality Improvement Matron, and Practice Standards Matron for Medicine. The programme is designed to develop clinical leadership skills through support and challenge and leading change and requires the completion of a service improvement in the clinical environment.

Optimising pathways

by:

- Improving multi-disciplinary engagement in clinical areas to improve patient flow.
- Maximising golden discharges and use of the discharge lounge.
- Collaborating with patients and service users to co-create pathways that best meet their needs.
- Creating pathways that are easy to use and access, so that patients are cared for in the right place and at the right time.
- Raising awareness of the Quality Improvement Hub, using it to create evidence-based care pathways.
- Promoting IT training for staff that supports new ways of working.
- Identifying more Digital Exemplar wards that will help us to make better use of our systems.

Improve patient flow:

We are embedding 'red to green' days where staff work together to ensure that every day is a 'green' day with something happening that contribtes towards a patients discharge, and reduce the number of 'red' days. This improved focus on progressing care and treatment and ensuring that all patients have an Estimated Date of Discharge helps to improve patient flow.

A **Red** day is when a patient receives little or no value adding acute care. The following questions should be considered:

- Could the care or interventions the patient is receiving today be delivered in a non-acute setting?
- If I saw this patient in out-patients, would their current 'physiological status' require emergency admission?

If the answers are 1. Yes and 2. No, then this is a 'Red bed day'

Examples of what constitutes a **Red** bed day:

- A planned investigation, clinical assessment, procedure or therapy intervention does not occur.
- The patient is in receipt of care that does not require an acute hospital bed.
- The medical care plan lacks a consultant approved expected date of discharge.
- There are no consultant approved physiological and functional clinical criteria for discharge in the medical care plan.

A RED day is a day of no value for a patient

A **Green** day is when a patient receives value adding acute care that progresses their progress towards discharge.

A **Green** day is a day when everything planned or requested gets done.

A **Green** day is a day when the patient receives care that can only be in an acute hospital bed.

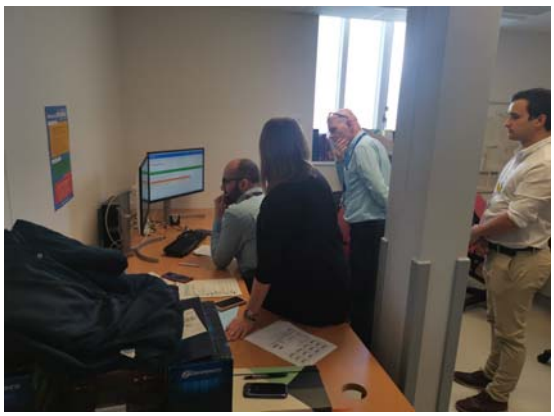
A GREEN day is a day of value for a patient

Golden discharges and discharge lounge:

We have introduced Golden discharges where ward staff identify patients for discharge and ensure they are taken to the discharge lounge early in the morning on the day of discharge. Substantive staff have been appointed to work within the discharge lounge. The discharge lounge has been re-located to Level 7 with additional space to care for patients before they go home. The policy for use of the discharge lounge has been updated and includes the key patient criteria.

Easy to use pathways of care:

The virtual fracture clinic was launched on 17 September 2019. Evidence shows that face to face attendance at a traditional fracture clinic after an injury is unnecessary in many cases. Our fracture clinics have been reconfigured for the patient's injuries to be assessed in a new, safe, effective and validated Virtual Fracture Clinic. Patients' documentation and x-rays are reviewed by an orthopaedic surgeon and an orthopaedic nurse will call the patient to discuss management/treatment of the injury.



Promoting IT training and supporting new ways of working:

Our Deputy Chief Nursing Information Officer continues to promote IT training for staff to support new ways of working by:

- Being a member of the non-medical education practice education committee
- Engaging with nurse education and maternity regarding the digital capabilities of staff
- Planning a digital capabilities assessment pilot in maternity / student nurses later in the autumn
- Being involved with the deteriorating patient quality improvement work on Ward 8a
- Engagement with and shadowing AHP's
- Engagement with the Trust's Clinical excellence framework
- Hardware audit of devices producing recommendations - what needs to change

Digital Exemplar wards:

- Patient Status at a Glance (PSAAG) was piloted on the Digital Exemplar Wards
- Staff from digital exemplar wards have been engaged in discussions, demonstrations and a and site visit relating to Electronic Prescribing and Medicine Administration (ePMA)

The Deputy Chief Nursing Information Officer will be shadowing staff to better understand 'what will make your life easier'.

Patient Status at a Glance Boards

We are rolling out new **patient status at a glance electronic boards** on all inpatient wards. This screen will display information digitally in real-time to assist clinical staff in providing patient care. It can be used to monitor patients by being able to view Early Warning Scores, observations and expected discharge dates.

Example of Patient Status at a Glance Board

Valuing people

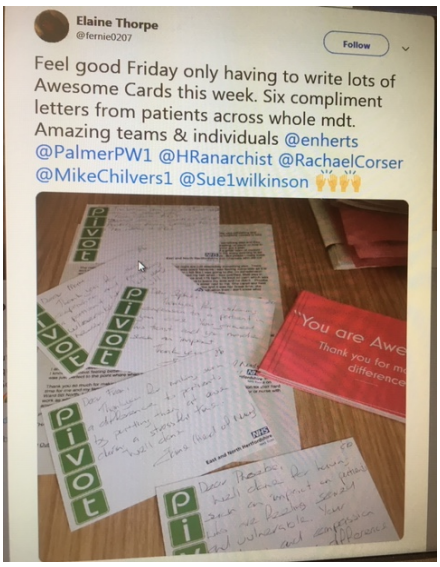
by:

- Fostering and environment where staff feel valued.
- Promoting excellence by using models of best practice.
- Recognising staff achievements and examples of outstanding care more often.
- Supporting good physical and mental well-being.
- Striving to be the first choice of employer for multi-professional staff.
- Championing personal development and resilience.
- Offering more education and training.
- Creating a culture that encourages continuous learning and well-being.

Valuing staff / Recognising staff achievements:

Our annual staff awards are a fantastic opportunity for us to celebrate the amazing care and compassion shown by our staff and recognise all of their hard work.

The Surgery Division have introduced the ***'You are Awesome'*** cards which are written and given to staff and teams who have gone above and beyond.



12 May 2019 was International Nurses Day which we celebrated with a huge thank you to all our colleagues for the high quality care they provide to patients.

Staff visited local schools to celebrate International Nurses Week. Pupils got to take part in a number of activities - including hand washing exercises, plastering and learning how to give teddy a blood test.

Colleagues from our nursing team were invited to Westminster Abbey to attend the Florence Nightingale Commemoration Service. The annual service is held to commemorate Florence Nightingale on her birthday and celebrate the great work our nurses do. Some of our nurses were also honoured to take part in the carrying of the Lamp procession, central to the annual ceremony.

Models of best practice:

Our **Golden discharges** award is presented to the ward who have identified the highest number of 'golden discharges' each week. Golden discharges are where patients are discharged from our care before 10am, providing a better patient experience and making sure we have space for new patients. We are also working collaboratively with operational colleagues to ensure that ward liaison officers are integral to the ward team.

The Trust is participating in a Hertfordshire wide quality improvement project with the aim of reducing urinary tract infections. It focusses on two wards on keeping patients well **hydrated**. An initial audit found that patients were only being offered four hot drink rounds per day and staff were not always free to assist patients when they were being offered drinks. Immediate actions were to commence an additional hot drinks round when the night staff came on duty. A bell was rung which prompted staff to help patients with their drinks. Simple signage was added to the patient's board indicating if the patient requires assistance with drinking.

The Trust is participating in a national programme led by NHS Improvement to improve pressure ulcer prevention care across the NHS – the **pressure ulcer collaborative**. The project aims to improve reporting of pressure related damage, increase quality improvement skills in trusts, reduce the number and severity of pressure ulcers, encourage a multi-professional approach to pressure ulcer prevention and provide information and tools to reduce patient pressure damage. The collaborative will begin on the 4 September and involve wards 6a and 8a before dissemination across the Trust.

Employer of choice for multi-professional staff:

We want to be the first choice of employer for staff and to create career pathways that will improve our workforce and the care we provide to patients.

We have launched a number of initiatives to recruit and retain staff over the past few months. These were mainly aimed at nursing but much of the initiatives were generic e.g. the recruitment materials for jobs fairs etc. are being used for all staff groups, and the employee referral scheme goes beyond nurses. We have also developed action plans for some hard to recruit professions such as pharmacy and radiology.

Additional actions include:

- Developing a quality careers website to highlight vacancies, careers and promote the Trust as an employer.
- Branded recruitment materials for use at job fair stands and for use in social media campaigns.
- Targeted advertising in social media.
- Incentives offered to Band 5 nurses who refer a band 5 nurse who goes on to be employed by the Trust.
- Attendance at job fairs
- Interest free loans offered to nurses coming to assist with visa renewal fees.
- Internal transfer scheme for Band 5 nurses to move around the Trust.
- Targeted student recruitment.
- Careers sessions for band 5 nurses.
- Review of open days
- Offering reduced accommodation costs to nurses as an incentive.
- Band 5 rotation guidance.
- Dedicated nursing recruitment and retention post.
- Marketing to overseas qualified nurses who may wish to seek registration in the UK.

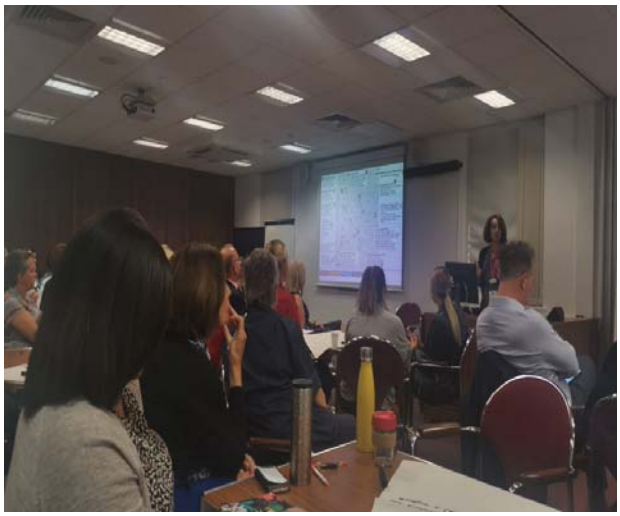
We are delighted to welcome the Allied Health Professional staff to the Trust – this includes occupational therapists, physiotherapists, dietitians etc.

We are also delighted to welcome our new Registered Nursing Associates, this new role supports nursing staff on the ward.

In August 2019 the Ministry of Defence awarded the Trust gold standard in recognition for being a top employer for people who have served in the armed forces and those who are reservists. The Trust offers flexible working, paid leave for reservists and a guaranteed interview scheme for ex-forces personnel who meet the essential criteria for a role.

Education and Training / Encourage Continuous Learning:

A Quality Improvement Learning Event took place on 21 June 2019 with all staff encouraged to drop in to learn about the importance of learning from patient safety incidents, our new quality and safety reporting dashboard and the new Quality Strategy.



East and North Hertfordshire NHS Trust

Quality Learning Event

21st June 2019

Open to all clinical and non-clinical staff

Lister Hospital Education Centre

TIME	TOPICS	SPEAKERS
08:30	**Refreshments and registration**	
09:00	Welcome & Introductions ENHT approach to Quality	Rachael Corser, Director of Nursing & Patient Experience
09:15	Enjoying work.....Quality Improvement for all	Tracey Van Wyk, IHI Quality Improvement Advisor, Head of Quality Improvement & Steve Andrew Associate Director Leadership & Change
10:15	Patient safety - Why bother reporting?	Jacqui Evans, Head of Patient Safety
10:35	Proud to improve our environment.	Infection control team
10:55	**Break**	
11:15	Improving quality through human factors in health care	Dr Jasmine Leonce & maternity team
11:35	Quality & Safety Dashboard – telling our story	Dan Booth, Head of Information and Business Intelligence
11:55	Why is Equality and Diversity important?	Mukesh Barot
12:55	**Lunch and refreshments provided**	
13:30	**Clinical Audit to Quality improvement** Clinical audit- How sick are our Patient's? The deteriorating patient - moving from reactive to proactive.	Dr Josh Hinton Amy Owen, CCOT Lead Jen Body, Resuscitation Lead
14:10	Right route, right patient, right dose, right time – how hard can it be?	Amaia Martinez Senosiain
14:30	Learning from deaths & introduction of the Medical Examiner	Sarah Shamoubi, Mortality Improvement Lead
14:50	Litigation overview and Duty of Candour	Lucinda Berry, Claims and Inquest Manager
15:10	**Afternoon break & refreshments**	
15:30	National Safety Standard for invasive Procedures (NatSSIP) – what is the ask?	Dr Ahilan Pathmanathan & Dr Emma Stevens
15:55	Celebrating Excellence – ENHT Framework	Karen Cameron
16:10	Working safely ....what do we mean?	*Suzette Woodward, National Director Sign up to Safety*
16:45	**Thank you**	Chaplin John O'Neill
17:00	**CLOSE**	

Inspiring and innovating through research and quality improvement

by:

- Promoting a culture of research and development.
- Providing clear guidance and governance that will support continuous quality improvement and research
- Developing up-to-date evidence-based best practice.
- Providing more learning opportunities – for example, in research coaching and quality improvement methodology.
- Encouraging more fellowship opportunities and applications from staff.
- Introducing a collaborative approach for research bids that will help advance and improve the health of our population.

Culture of research and quality improvement:

We are preparing a community of practice for all staff to attend, which will launched in early 2020, where staff can share best practice and drive forward new initiatives to support research activity. A research newsletter has been developed, including information on upcoming events (Research Evidence Champion, Community of Practice, PPI), research opportunities, main research contacts.

Research Evidence Champion (joint initiative with the Library):

This was launched in September and the first meeting will be held in November.

Learning opportunities:

The National Institute of Health Research (NIHR) 70@70 Senior Research Nurse Leader was launched in May. This programme aims to support capacity development for nurses/midwives in 70 trusts across England. One of our senior research nurses was appointed to this role in May. The 70@70 nurses meet monthly to share their experiences and plans for the role, and undertake educational training.

The University of Hertfordshire/ ENHT Critical Appraisal Course is aimed at raising critical awareness of how to use evidence (qualitative and quantitative) in clinical practice. The first study day in July was well attended by all health professionals, from nurses to radiographers and consultants. The second study day will take place in September.

Research supporting the Clinical Excellence Framework:

The research team support the pilot wards during their preparation for ward assessment. Several wards have their research boards up with research information.

Patient, Public Involvement panel:

We launched the inaugural patient, public involvement panel in May this year, with patients and public members coming together to learn about research and influence research to be undertaken at ENHT. The next meeting will be held in November.

To celebrate International Clinical Trials Day, our research team met both patients and staff at the Lister and Mount Vernon Cancer Centre to talk about the work they do and the numerous cancer trials on-going at the Trust. As a research active Trust, the team encourages patients to have an open conversation with their consultant about potential studies.

Fellowships:

Following last year's success, we have had several applicants for fellowships (research/practice), we are awaiting to hear on some but have had one recent successful Applied Research Collaborative application in the Acute Kidney Injury (AKI) team.

Research Bids:

A request for a full time research midwife funding from the National Institute of Health Research Clinical Research Network (Eastern) was submitted in September to broaden the research portfolio beyond nursing.

Nurse-led grant submissions to funding/grant bodies continue to be led/facilitated by our Professor in Nursing Research.

Ensuring quality and safety

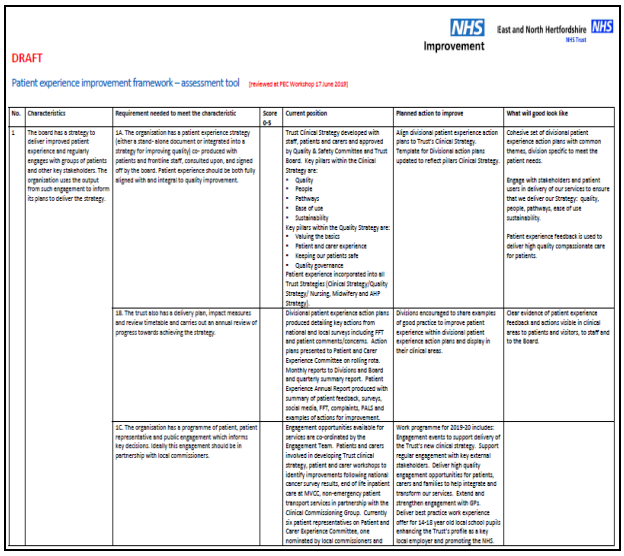
by:

- Delivering excellent and compassionate care consistently, reflecting the values of the Trust and our professions.
- Using our quality dashboard and nursing quality indictors to make informed decisions that will continue to improve patient care.
- Making realistic, sustainable and aspirational improvements to quality and safety.
- Creating career pathways that will improve our workforce and the care we provide.
- Introducing a ward accreditation scheme that will promote and recognise outstanding care.
- Using learning from incidents to drive best practice and improvements.

Delivering compassionate care:

The Trust's Patient and Carer Experience Committee are leading on the NHS Improvement Patient Experience Framework self-assessment which aims to establish how far patient experience is embedded in the Trust's leadership, culture and operational processes. The assessment tool is divided into six sections and, contained within each of these, are the characteristics and processes of organisations that are effective in continuously improving the experience of patients. We have started to assess our performance against:

- Leadership
- Organisational culture
- Capacity and capability to effectively collect feedback
- Analysis and triangulation
- Using patient feedback to drive quality improvement and learning
- Reporting and publication



DRAFT

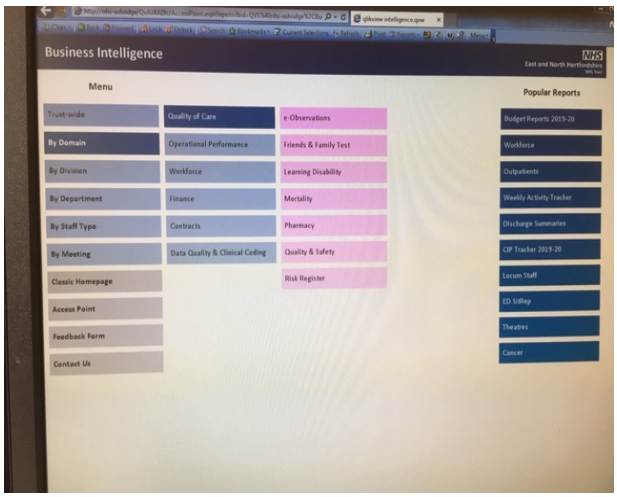
Patient experience improvement framework – assessment tool [reviewed at PEC Workshop 17 June 2019]

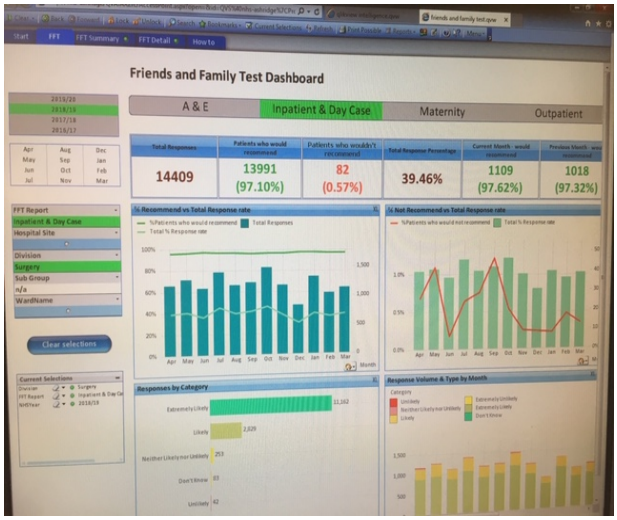
No.	Characteristics	Requirement needed to meet the characteristic	Score 0-5	Current position	Planned action to improve	What will good look like
1	The board has a strategy to deliver improved patient experience and regularly engages with groups of patients and other key stakeholders. The organisation uses the output from such engagement to inform its plans to deliver the strategy.	1A. The organisation has a patient experience strategy (either a stand- alone document or integrated into a strategy for improving quality) co- produced with patients and frontline staff, consulted upon, and signed off by the board. Patient experience should be both fully aligned with and integral to quality improvement.		Trust Clinical Strategy developed with staff, patients and carers and approved by Quality & Safety Committee and Trust Board. Key pillars within the Clinical Strategy are: • Quality • People • Pathways • Ease of use • Sustainability Key pillars within the Quality Strategy are: • Valuing the basics • Patient and carer experience • Keeping our patients safe • Quality governance Patient experience incorporated into all Trust Strategies (Clinical Strategy/Quality Strategy/ Nursing, Midwifery and AHP Strategy)	Align divisional patient experience action plans to Trust's Clinical Strategy. Template for Divisional action plans updated to reflect pillars Clinical Strategy.	Cohesive set of divisional patient experience action plans with common themes, division specific to meet the patient needs. Engage with stakeholders and patient users in delivery of our services to ensure that we deliver our Strategy: quality, people, pathways, ease of use sustainability. Patient experience feedback is used to deliver high quality compassionate care for patients.
		1B. The trust also has a delivery plan, impact measures and review timetable and carries out an annual review of progress towards achieving the strategy.		Divisional patient experience action plans produced detailing key actions from national and local surveys including FFT and patient comments/concerns. Action plans presented to Patient and Carer Experience Committee on rolling rota. Monthly reports to Divisions and Board and quarterly summary report. Patient Experience Annual Report produced with summary of patient feedback, surveys, social media, FFT, complaints, PALS and examples of actions for improvement.	Divisions encouraged to share examples of good practice to improve patient experience within divisions/ patient experience action plans and display in their clinical areas.	Clear evidence of patient experience feedback and actions visible in clinical areas to patients and visitors, to staff and to the Board.
		1C. The organisation has a programme of patient, patient representative and public engagement which informs key decisions. Ideally this engagement should be in partnership with local commissioners.		Engagement opportunities available for services are co-ordinated by the Engagement Team. Patients and carers involved in developing Trust clinical strategy, patient and carer workshops to identify improvements following national cancer survey results, end of life inpatient care at MVCC, non-emergency patient transport services in partnership with the Clinical Commissioning Group. Currently six patient representatives on Patient and Carer Experience Committee, one nominated by local commissioners and	Work programme for 2019-20 includes: Engagement events to support delivery of the Trust's new clinical strategy. Support regular engagement with key external stakeholders. Deliver high quality engagement opportunities for patients, carers and families to help integrate and transform our services. Extend and strengthen engagement with GPs. Deliver best practice work experience offer for 14-15 year old local school pupils enhancing the Trust's profile as a key local employer and promoting the NHS.	

Extract from Patient Experience Framework self-assessment

Quality dashboard:

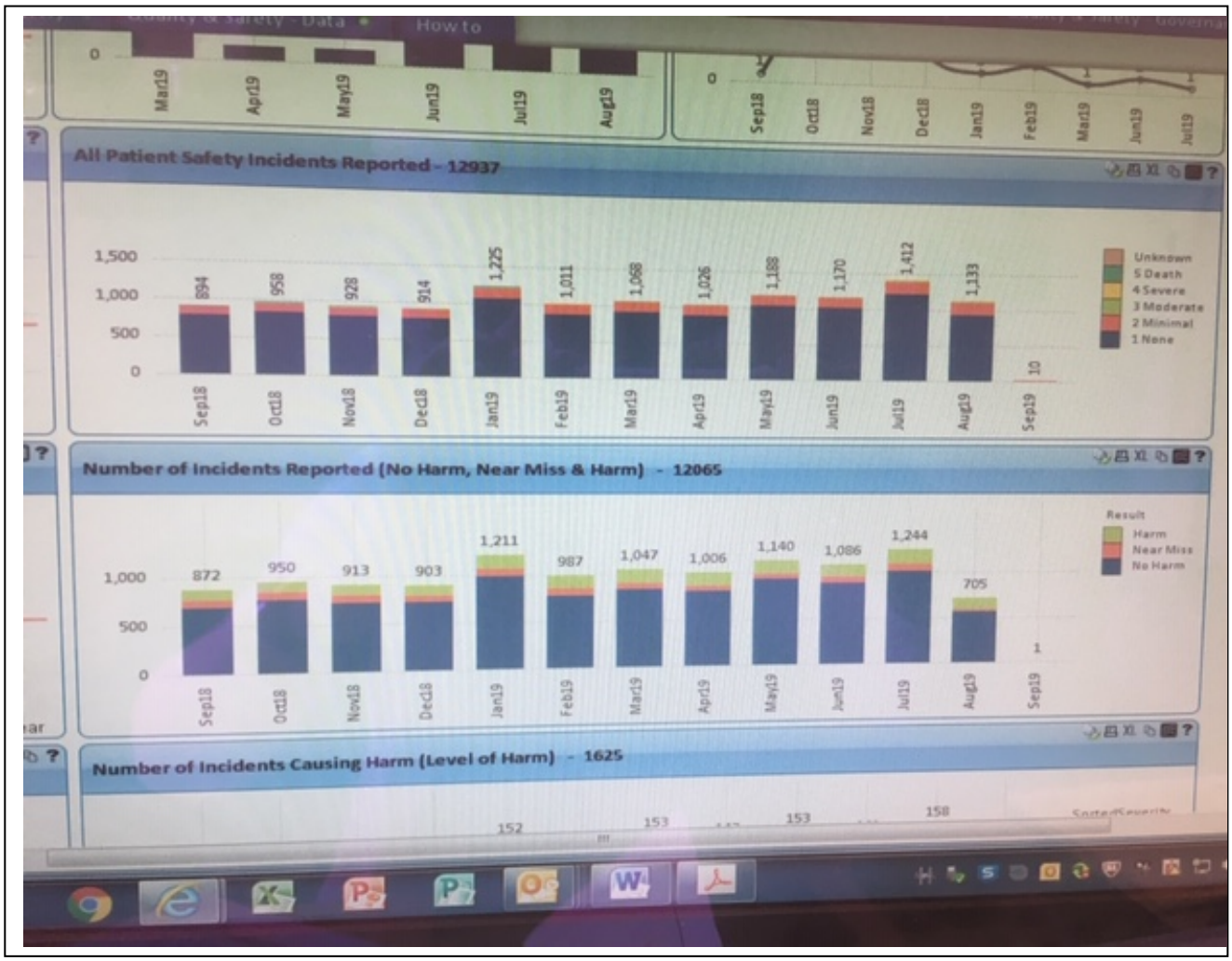
The QlikView business intelligence system enables staff to access key information on quality, operational performance, workforce, finance, contracts, data quality and clinical coding.





Extracts from QlikView

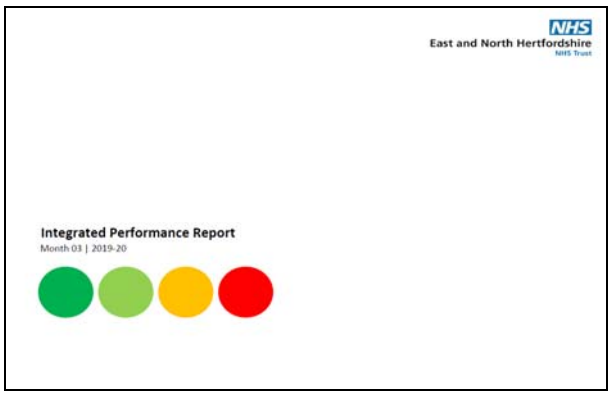

Start
Quality & Safety - Patient Safety
Quality & Safety - Pressure Ulcers (UAT)
Quality & Safety - Falls (UAT)
Quality & Safety - Data
How to
Q&S - Patient Safety Indicators
2016/17
2017/18
2018/19
2019/20
Site
Division
Location (type)
Location (exact)
Serious Incidents Reported
18
Never Events Reported
1
Serious Incidents Under Investigation
14
Serious Incident Reports Overdue
3
Patient Safety Incident Reports
4796
Serious Incidents Reported - 58
Serious Incidents Under Investigation - 21


All Patient Safety Incidents Reported - 12937
Unknown
5 Death
4 Severe
3 Moderate
2 Minimal
1 None
Number of Incidents Reported (No Harm, Near Miss & Harm) - 12065
Result
Harm
Near Miss
No Harm
Number of Incidents Causing Harm (Level of Harm) - 1625

Integrated Performance Report

Our new Integrated Performance Report ensures that all key quality and safety data is reported and progress over time measured. The report includes:

- Performance headlines
- Single oversight framework
- Safe services
- Effective services
- Well-led services
- Quality improvement
- Caring services
- Responsive services
- Sustainable services



Single Oversight Framework

Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Caring	Written complaints - rate	Quarterly	Jun-19	Local	1.9	1.8	
Caring	Staff Friends and Family Test % recommended - care	Quarterly	Q1 2019-20	National	80.9%	67.8%	
Safe	Occurrence of any Never Event	Monthly (six-month rolling)	Jun-19	National	0	0	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Jul-19	National	0	5	
Caring	Mixed-sex accommodation breaches	Monthly	Jun-19	National	0	0	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	Jun-19	National (excl. IS)	95.0%	96.9%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	Jun-19	National (excl. IS)	90.0%	92.7%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	Jun-19	National (excl. IS)	93.0%	100.0%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	Jun-19	National (excl. IS)	93.0%	97.3%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	Jun-19	National (excl. IS)	93.0%	86.5%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	Jun-19	National (excl. IS)	93.0%	100.0%	
Safe	Emergency c-section rate	Monthly	Jun-19	Local	15%	16%	
Organisational health	CQC inpatient survey	Annual	2018	National	8.0	7.8	
Safe	Venous thromboembolism (VTE) risk assessment	Quarterly	Q4 2018-19	National	95%	96.3%	
Safe	Clostridium difficile (C. difficile) plan: C.difficile actual variance from plan (actual number v plan number)	Monthly	Jun-19	National	0	-2	
Safe	Clostridium difficile – infection rate	Monthly (12-month rolling)	Jun-19	National	10.10	12.03	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Jun-19	National	0.63	0.48	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly (12-month rolling)	Jun-19	National	8.10	6.74	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Monthly (12-month rolling)	Jun-19	National	18.56	16.36	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Mar-19	National	100	93.3	
Effective	Summary Hospital-level Mortality Indicator	Quarterly	Mar-18-Feb-19	National	100	91.9	
Safe	Potential under-reporting of patient safety incidents	Monthly (12-month rolling)	May-19	National	11.3	18.9	

Example from IPR report - Quality of Care

Example from IPR report –
improvements in complaint response times:

Metric	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	
Proportion of complaints responded to within agreed timeframe	80%	52%	52%	47%	43%	53%	55%	64%	63%	64%	78%	76%	80%	

Nursing and Midwifery Quality Indicators:

Our monthly Nursing and Midwifery Quality Indicators report includes key data broken down by ward and division to enable monitoring of:

Number of ***beds*** and % bed occupancy.

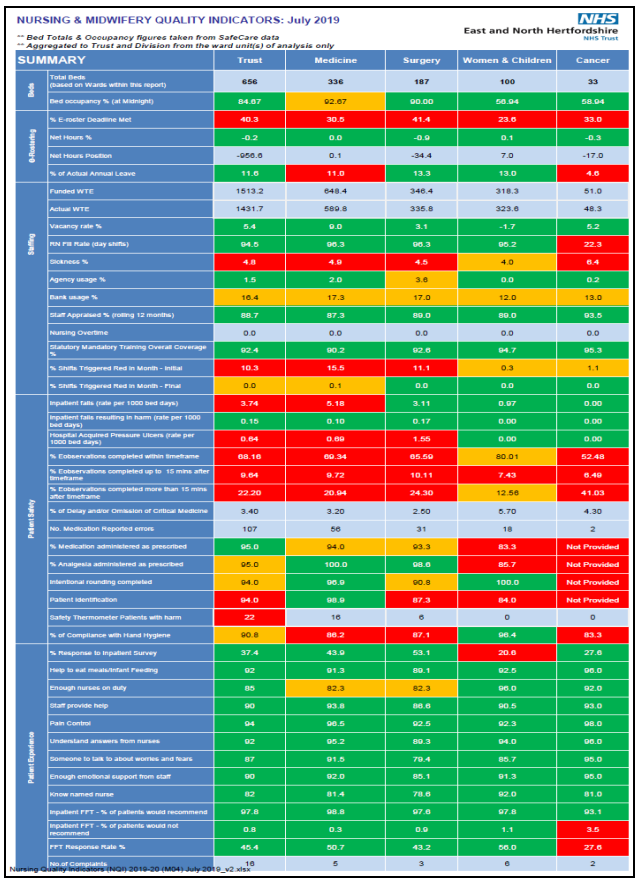
E-rostering including % e-roster meeting deadline, net hours position and % annual leave.

Funded and actual ***staffing*** establishment, vacancy rate, planned-v-actual hours worked, sickness, agency/bank usage, staff appraisal, overtime, statutory training, wards triggered red in month and wards stayed red.

Patient safety including falls and those resulting in serious harm, hospital acquired pressure ulcers, % NEWS score completion and escalation, medication administration errors, omissions in providing patient medication, delays of >30 minutes for pain relief, omission of essential nursing care documentation, number of safety thermometer patients with harm and compliance with hand hygiene.

Patient experience including the Friends and Family Test (FFT) % of patients who would/would not recommend the ward, response rate and patient responses to questions within the inpatient survey: enough nurses on duty, enough emotional support, someone to talk to about worries and fears, know who named nurse is, understandable answers to questions from nurses, pain control, response to call button and help from staff to eat meals.

The Nursing and Midwifery Quality Indicators are regularly reviewed within Divisions and by the Trust's Nursing and Midwifery Executive Committee. Divisional Heads of Nursing lead on the development and implementation of action plans to address areas of concern identified.



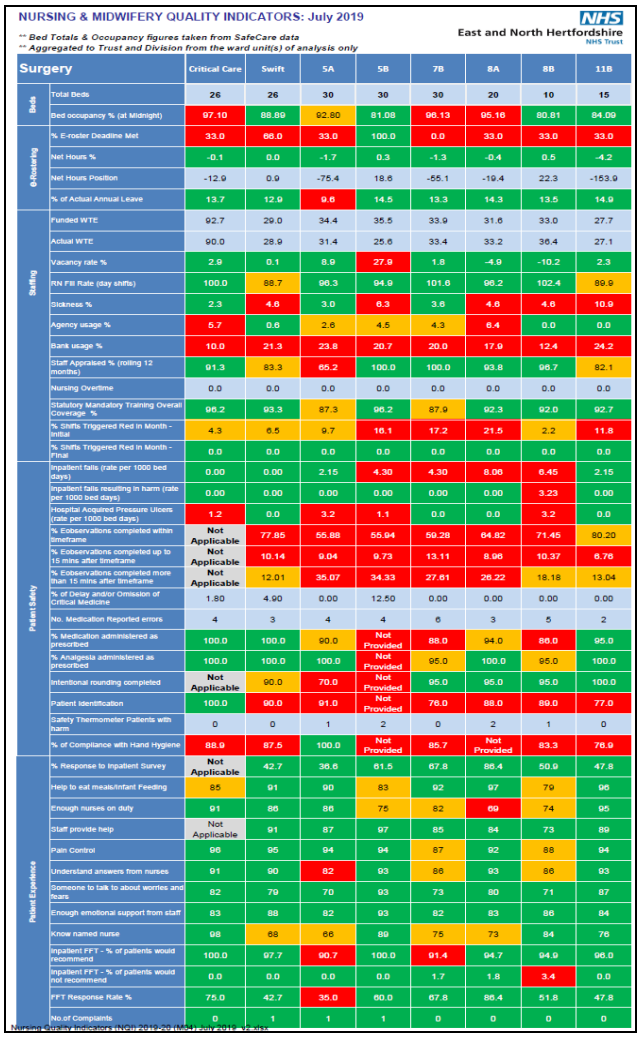
NURSING & MIDWIFERY QUALITY INDICATORS: July 2019

East and North Hertfordshire NHS Trust

** Bed Totals & Occupancy figures taken from SafeCare data
** Aggregated to Trust and Division from the ward unit(s) of analysis only

SUMMARY		Trust	Medicine	Surgery	Women & Children	Cancer
Beds	Total Beds (based on Wards within this report)	656	336	187	100	33
	Bed occupancy % (at Midnight)	84.67	92.67	90.00	56.94	58.94
E-Rostering	% E-roster Deadline Met	40.3	38.5	41.4	23.6	33.0
	Net Hours %	-0.2	0.0	-0.9	0.1	-0.3
	Net Hours Position	-956.6	0.1	-34.4	7.0	-17.0
	% of Actual Annual Leave	11.6	11.0	13.3	13.0	4.6
Staffing	Funded WTE	1513.2	648.4	346.4	318.3	51.0
	Actual WTE	1431.7	589.8	335.6	323.6	48.3
	Vacancy rate %	5.4	9.0	3.1	-1.7	5.2
	RN Fill Rate (day shifts)	94.5	98.3	96.3	95.2	22.3
	Sickness %	4.8	4.9	4.5	4.0	6.4
	Agency usage %	1.5	2.0	3.6	0.0	0.2
	Bank usage %	16.4	17.3	17.0	12.0	13.0
	Staff Appraised % (rolling 12 months)	88.7	87.3	89.0	89.0	93.5
	Nursing Overtime	0.0	0.0	0.0	0.0	0.0
	Statutory Mandatory Training Overall Coverage %	92.4	90.2	92.6	94.7	95.3
	% Shifts Triggered Red in Month - Initial	10.3	15.5	11.1	0.3	1.1
	% Shifts Triggered Red in Month - Final	0.0	0.1	0.0	0.0	0.0
Patient Safety	Inpatient falls (rate per 1000 bed days)	3.74	5.18	3.11	0.97	0.00
	Inpatient falls resulting in harm (rate per 1000 bed days)	0.15	0.10	0.17	0.00	0.00
	Hospital Acquired Pressure Ulcers (rate per 1000 bed days)	0.64	0.69	1.55	0.00	0.00
	% Eobservations completed within timeframe	68.16	69.34	65.59	80.01	52.48
	% Eobservations completed up to 15 mins after timeframe	9.64	9.72	10.11	7.43	6.49
	% Eobservations completed more than 15 mins after timeframe	22.20	20.94	24.30	12.56	41.03
	% of Delay and/or Omission of Critical Medicine	3.40	3.20	2.50	5.70	4.30
	No. Medication Reported errors	107	56	31	18	2
	% Medication administered as prescribed	95.0	94.0	93.3	83.3	Not Provided
	% Analgesia administered as prescribed	95.0	100.0	98.6	85.7	Not Provided
	Intentional rounding completed	94.0	96.9	90.8	100.0	Not Provided
	Patient identification	94.0	98.9	87.3	84.0	Not Provided
	Safety Thermometer Patients with harm	22	16	6	0	0
	% of Compliance with Hand Hygiene	90.8	86.2	87.1	96.4	83.3
Patient Experience	% Response to Inpatient Survey	37.4	43.9	53.1	20.6	27.6
	Help to eat meals/Infant Feeding	92	91.3	89.1	92.5	96.0
	Enough nurses on duty	85	82.3	82.3	96.0	92.0
	Staff provide help	90	93.8	86.6	90.5	93.0
	Pain Control	94	96.5	92.5	92.3	98.0
	Understand answers from nurses	92	95.2	89.3	94.0	96.0
	Someone to talk to about worries and fears	87	91.5	79.4	85.7	95.0
	Enough emotional support from staff	90	92.0	85.1	91.3	95.0
	Know named nurse	82	81.4	78.6	92.0	81.0
	Inpatient FFT - % of patients would recommend	97.8	98.8	97.6	97.8	93.1
	Inpatient FFT - % of patients would not recommend	0.8	0.3	0.9	1.1	3.5
	FFT Response Rate %	45.4	50.7	43.2	56.0	27.6
	No.of Complaints	18	5	3	6	2

Nursing Safety Indicators ENGH 2018-20 (M04) July 2019_v2.xlsx



NURSING & MIDWIFERY QUALITY INDICATORS: July 2019

East and North Hertfordshire NHS Trust

** Bed Totals & Occupancy figures taken from SafeCare data
** Aggregated to Trust and Division from the ward unit(s) of analysis only

Surgery		Critical Care	Swift	5A	5B	7B	8A	8B	11B
Beds	Total Beds	26	26	30	30	30	20	10	15
	Bed occupancy % (at Midnight)	97.10	88.89	92.80	81.08	96.13	95.16	80.81	84.09
E-Rostering	% E-roster Deadline Met	33.0	66.0	33.0	100.0	0.0	33.0	33.0	33.0
	Net Hours %	-0.1	0.0	-1.7	0.3	-1.3	-0.4	0.5	-4.2
	Net Hours Position	-12.9	0.9	-75.4	18.6	-55.1	-19.4	22.3	-153.9
	% of Actual Annual Leave	13.7	12.9	9.6	14.5	13.3	14.3	13.5	14.9
Staffing	Funded WTE	92.7	29.0	34.4	35.5	33.9	31.6	33.0	27.7
	Actual WTE	90.0	28.9	31.4	25.6	33.4	33.2	36.4	27.1
	Vacancy rate %	2.9	0.1	8.9	27.9	1.8	-4.9	-10.2	2.3
	RN Fill Rate (day shifts)	100.0	88.7	96.3	94.9	101.6	96.2	102.4	89.9
	Sickness %	2.3	4.6	3.0	6.3	3.6	4.6	4.6	10.9
	Agency usage %	5.7	0.6	2.6	4.5	4.3	6.4	0.0	0.0
	Bank usage %	10.0	21.3	23.8	20.7	20.0	17.9	12.4	24.2
	Staff Appraised % (rolling 12 months)	91.3	83.3	85.2	100.0	100.0	93.8	96.7	82.1
	Nursing Overtime	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Statutory Mandatory Training Overall Coverage %	96.2	93.3	87.3	96.2	87.9	92.3	92.0	92.7
	% Shifts Triggered Red in Month - Initial	4.3	6.5	9.7	16.1	17.2	21.5	2.2	11.8
	% Shifts Triggered Red in Month - Final	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Patient Safety	Inpatient falls (rate per 1000 bed days)	0.00	0.00	2.15	4.30	4.30	8.06	6.45	2.15
	Inpatient falls resulting in harm (rate per 1000 bed days)	0.00	0.00	0.00	0.00	0.00	0.00	3.23	0.00
	Hospital Acquired Pressure Ulcers (rate per 1000 bed days)	1.2	0.0	3.2	1.1	0.0	0.0	3.2	0.0
	% Eobservations completed within timeframe	Not Applicable	77.85	55.88	55.94	59.28	64.82	71.45	80.20
	% Eobservations completed up to 15 mins after timeframe	Not Applicable	10.14	9.04	9.73	13.11	8.96	10.37	6.76
	% Eobservations completed more than 15 mins after timeframe	Not Applicable	12.01	35.07	34.33	27.61	26.22	18.18	13.04
	% of Delay and/or Omission of Critical Medicine	1.80	4.90	0.00	12.50	0.00	0.00	0.00	0.00
	No. Medication Reported errors	4	3	4	4	6	3	5	2
	% Medication administered as prescribed	100.0	100.0	90.0	Not Provided	88.0	94.0	86.0	95.0
	% Analgesia administered as prescribed	100.0	100.0	100.0	Not Provided	95.0	100.0	95.0	100.0
	Intentional rounding completed	Not Applicable	90.0	70.0	Not Provided	95.0	95.0	95.0	100.0
	Patient identification	100.0	90.0	91.0	Not Provided	76.0	88.0	89.0	77.0
	Safety Thermometer Patients with harm	0	0	1	2	0	2	1	0
	% of Compliance with Hand Hygiene	88.9	87.5	100.0	Not Provided	85.7	Not Provided	83.3	76.9
Patient Experience	% Response to Inpatient Survey	Not Applicable	42.7	36.6	61.5	67.8	66.4	50.9	47.8
	Help to eat meals/Infant Feeding	85	91	90	83	92	97	79	96
	Enough nurses on duty	91	86	86	75	82	69	74	95
	Staff provide help	Not Applicable	91	87	97	85	84	73	89
	Pain Control	96	95	94	94	87	92	88	94
	Understand answers from nurses	91	90	82	93	86	93	86	93
	Someone to talk to about worries and fears	82	79	70	93	73	80	71	87
	Enough emotional support from staff	83	88	82	93	82	83	86	84
	Know named nurse	98	88	66	89	75	73	84	76
	Inpatient FFT - % of patients would recommend	100.0	97.7	90.7	100.0	91.4	94.7	94.9	96.0
	Inpatient FFT - % of patients would not recommend	0.0	0.0	0.0	0.0	1.7	1.8	3.4	0.0
	FFT Response Rate %	75.0	42.7	35.0	60.0	67.8	86.4	51.8	47.8
	No.of Complaints	0	1	1	1	0	0	0	0

Nursing Safety Indicators ENGH 2018-20 (M04) July 2019_v2.xlsx

Career pathways:

An unqualified/qualified nursing career pathway is in place and further work is being undertaken on apprenticeships as an aid to map out clear career pathway options for all levels and different professions.

We have introduced a scheme for band 5 nurses to develop to band 6 roles. This is a 12 month pathway giving Band 5 nurses the skills and knowledge they need to apply for a Band 6 post. On successful completion staff will go onto a database to apply for Band 6 vacancies.

Clinical Excellence Accreditation Programme:

The Clinical Excellence Accreditation framework provides a roadmap for improvements that enables wards/departments to determine their journey and share their good news stories. It brings together key measures of nursing and clinical care to enable a comprehensive assessment of the quality of patient safety and patient experience at ward/department level.

Wards are assessed against the following pillars:

Pillar 1: Developing and strengthening leadership
Pillar 2: Optimising pathways
Pillar 3: Valuing people
Pillar 4: Inspiring and innovating through research and quality improvement
Pillar 5: Ensuring quality and safety
Pillar 6: Partnership working

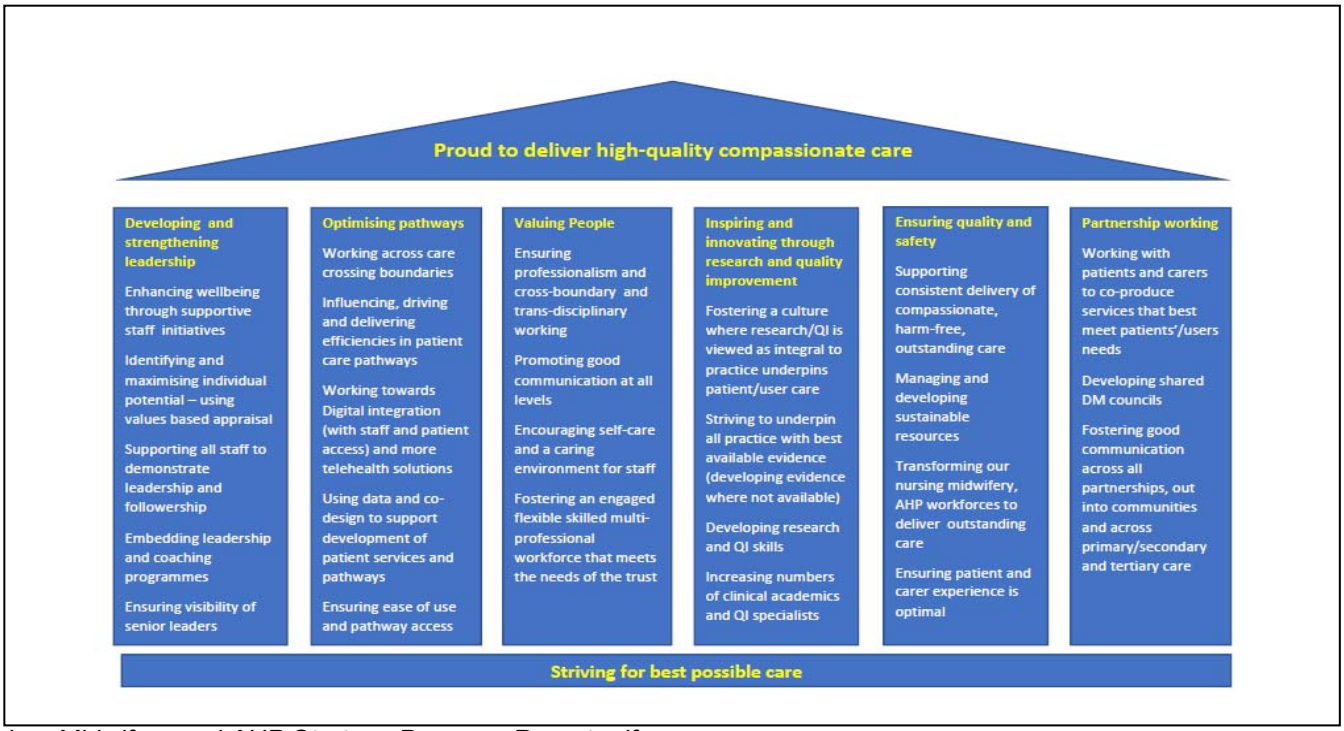
Clinical Excellence Framework - Standards and Measures

PILLAR 1 : Developing and Strengthening Leadership

	Standard	CQC Domain	Data Source	Calculation
1	Percentage of staff who have been in post for more than one year. Ward establishment WTE - RN, CSW,RNA Ward Clerk, Housekeeper	Effective, Well-led, Safe	ESR and QlikView	Number of staff in post and number of staff in post for over a year
2	Percentage of staff who would recommend the ward or unit as a place to receive treatment	Safe	Ward staff survey	Number of staff in post and number who would recommend the ward ot unit as a place to receive treatment
3	Percentage of volunteers (if applicable) who would recommend the ward or unit as a place to receive treatment	Safe	Ward volunteer survey	Number of volunteers in post and number who would recommend ENHT as a place to receive treatment
4	Proportion of staff that would recommend the ward as a place to work	Well-led	Ward staff survey and FFT	Number of staff in post and number of staff who would recommend ENHT as a place to work
5	Proportion of volunteers (if applicable) that would recommend the ward as a place to work	Well-led	Volunteer survey	Number of volunteers in post and number of volunteers who would recommend ENHT as a place to work
6	Proportion of eligible staff competent in four core competencies	Well-led, safe, effective	E roster	Number of staff in post and number of staff who have achieved four core competencies : blood transfusion, nasogastric tube, cannulation, observations are identified as part of e roster skill mix
7	Proportion of staff identified on ward establishment who have completed statutory training	Safe, effective, well- led	ESR , Monthly Nursing and Midwifery Quality Indicators	Total number of staff and number of staff who have completed statutory training according to trust target
8	Proportion of staff identified on ward establishment who have completed mandatory training	Safe, effective, well led	ESR , Monthly Nursing and Midwifery Quality Indicators	Total number of staff and number of staff who have completed mandatory training according to trust target

Four wards have completed their self-assessment for accreditation and are currently going through the assessment process.

Teams strive for improvement through four levels of accreditation – bronze, silver, gold and platinum.



Pathway to Excellence®

The Trust has been successful in joining the first cohort of Trusts taking forward the Pathway to Excellence® programme. We strive for excellence and continuous improvement and are committed to supporting colleagues to embed excellence within a culture of strong clinical leadership and positive staff and engagement. These ambitions are demonstrated in our Trust Strategy, Vision and Values.

The Trust's Quality Strategy focuses on four quality pillars:

- Valuing the basics
- Keeping our patients safe
- Patient and carer experience
- Quality governance

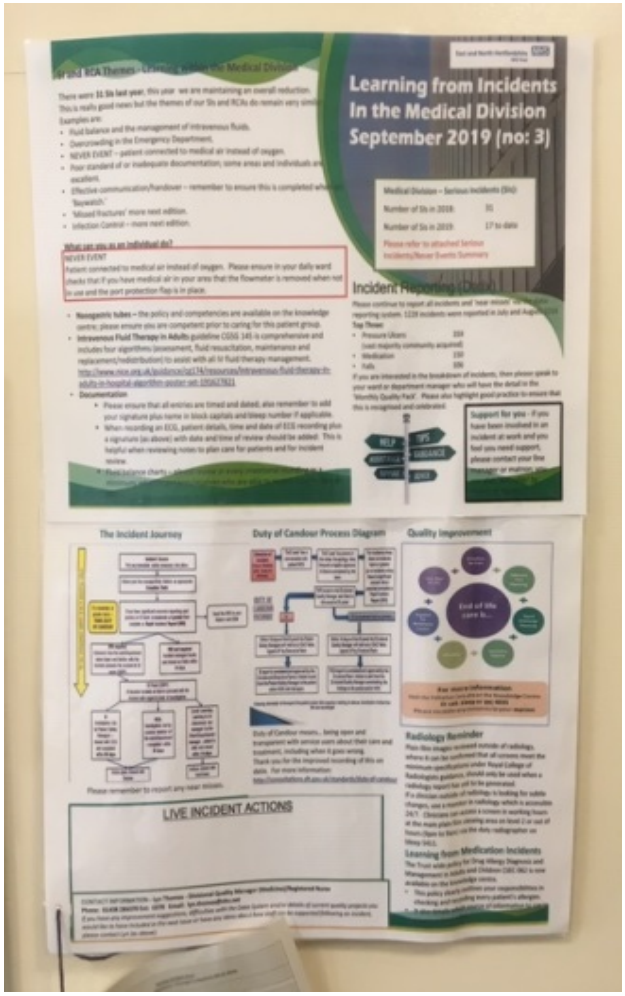
Learning from incidents:

Incidents are recorded on the Datix system and an analysis of the incidents reported undertaken by the Patient Safety Team for common themes. An average of 994 incidents are reported each month. Examples of incidents reported include:

- Pressure ulcers
- Falls
- Breaches in the Emergency Department
- Blood transfusion
- Staffing
- Infection control
- Child protection
- Sharps

Around 97% of these incidents result in none or minimum harm. Incidents reported are reviewed by the manager and any incident which has led to moderate harm and above generates a rapid incident report to the Serious Incident Review Panel which meets twice weekly. The Divisional Quality Managers produce a rapid incident report which includes learning from the incident.

The Deteriorating Patient Collaborative and Harm Free Care Collaborative have detailed improvement plans that reflect incident action plans.



Medicine Division – Example of Learning from Incidents

Partnership working

by:

- Improving our engagement with patient experience groups, as well as other local partners.
- Encouraging innovation across all levels, from the frontline to wider developments across the Sustainability and Transformation Partnership (STP).
- Sharing the Trust's strategy with our partners, making sure our vision aligns with local health priorities.

Engagement with Patient Experience Groups

Membership of the Trust's Patient and Carer Experience Committee has been reviewed and four new patient representatives welcomed to the group. A representative from Healthwatch is also included on the membership. The committee meets monthly rotating between formal meetings and more informal workshops where the group can spend time focussing on one or two issues. This is a fantastic opportunity for teams to hear direct from patients their views on the services we provide and their ideas for improvements.

Partnership working with AHPs

The Trust have been delighted to welcome Therapy Services who joined in April 2019. This service includes Occupational Therapists, Physiotherapists and Therapy support workers previously employed by Herts Community NHS Trust. Bringing these staff groups 'in-house' has provided greater opportunity for them to input into all of the initiatives outlined in the previous sections and to strengthen the working relationships across the multi-disciplinary team. The therapy service have developed initiatives to improve patient flow and discharge co-ordination. They bring expertise in assessment of patient function, discharge pathway identification and complex patient management.

The therapy service bring a wealth of partnership networks across the STP. They understand the importance of linking with their community colleagues and meet regularly to improve the patient experience across all pathways.

Annual General Meeting – 17 July 2019

The Trust's annual general meeting held in July was an opportunity to share with the public information about our performance over the year and plans for the future.

A wide range of organisations joined the marketplace displays sharing information about their services, this included:

- NHS Retirement, Stevenage
- HertsHelp
- Stevenage FC Foundation
- East and North Hertfordshire Clinical Commissioning Group
- Healthwatch
- MIND
- North Herts Council for Voluntary Services
- National Institute for Health Research
- Stevenage Borough Council
- Carers in Hertfordshire
- Crossroads