Public Trust Board

Mount Vernon Cancer Centre

NHS East and North Hertfordshire NHS Trust

03/05/2023 10:30 - 12:30

11.	Staff Survey Results	Thomas Pounds - Chief People Officer	11:20-11:35	52

For discussion

ASSURANCE AND GOVERNANCE ITEMS

12.	Scheme of Delegation and Standing Orders	Stuart Dalton - Head of Corporate Governance	11:35-11:40	67

For approval

13.	Learning From Deaths Report	Justin Daniels - Medical Director	11:40-11:45	167

For noting

PERFORMANCE

14.	Integrated Performance Report	All Directors	11:45-12:00	172

For discussion

15.	System Performance Report	Martin Armstrong - Chief Finance Officer & Deputy CEO	12:00-12:05	219

For discussion

COMMITTEE REPORTS

16.	Finance, Performance and Planning Committee Report to Board	Chair of FPPC		264

For noting

17.	Quality and Safety Committee Report to Board	Chair of QSC		268

For noting

18.	Audit & Risk Committee Report to Board	Chair of Audit & Risk Committee		272

For noting

19.	People Committee Report to Board	Chair of People Committee		274

For noting

20.	Charity Trustee Committee	Chair of Charity Trustee Committee		275

For noting

OTHER ITEMS

21.	Annual Cycle	Trust Chair		277

For noting

22.	Any Other Business	Trust Chair

For noting

23.	Date of Next Meeting - Wednesday 5 July 2023	Trust Chair

For noting

East and North Hertfordshire NHS Trust

Agenda item: 4

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 1 March 2023 at 10.30am in the Lister Education Training Centre, Lister Hospital, Stevenage

Present:	Mrs Ellen Schroder	Trust Chair
	Mrs Karen McConnell	Deputy Trust Chair and Non-Executive Director
	Mr Jonathan Silver	Non-Executive Director
	Dr Peter Carter	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Dr David Buckle	Non-Executive Director
	Mr Adam Sewell-Jones	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance & Deputy Chief Executive Officer
	Dr Michael Chilvers	Medical Director
	Ms Lucy Davies	Chief Operating Officer
	Ms Theresa Murphy	Chief Nurse
	Mr Thomas Pounds	Chief People Officer
	Mr Kevin Howell	Director of Estates and Facilities
From the Trust:	Mr Stuart Dalton	Head of Corporate Governance
	Mrs Eilidh Murray	Assistant Director of Communications and Engagement (via MS Teams)
	Mrs Sylvia Gomes	Freedom to Speak Up Guardian (FTSUG) (Item 22/175)
	Ms Michelle Irvine	Cardiac Physiologist (Item 22/175)
	Ms Katherine Marwood	Programme Director deputising for Director of Improvement
	Ms Julia Smith	Assistant Trust Secretary (Minutes)
Members of the Public:	Pfizer representative	

No	Item	Action
22/169	**CHAIR'S OPENING REMARKS** Ms Schroder welcomed Mrs Gomes and Ms Irvine who would present the staff story. She also welcomed Ms Marwood and thanked her for deputising for the Director of Improvement.	
22/170	**APOLOGIES FOR ABSENCE** Apologies were received from: Kevin O'Hart – Director of Improvement	
22/171	**DECLARATIONS OF INTEREST** There were no new declarations of interest made.	

East and North Hertfordshire NHS Trust

22/172 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 11 January 2023 were **APPROVED** as an accurate record of the meeting subject to minor changes by Mrs Schroder.

22/173 ACTION LOG

The Board agreed to move the management of the smoking action would be through the Quality and Safety committee and a quarterly update would be provided to the Public Trust Board.

The Board **NOTED** the current Action Log.

22/174 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

22/175 STAFF STORY

Mr Pounds introduced Ms Irvine and Mrs Gomes and explained to the Board that the staff story was important as it followed-up the civility video previously seen by the Board.

Mrs Gomez informed the Board that she had raised the issue and a resolution was achieved due to the collaboration of the team involved.

Ms Irvine explained to the Board that she came to the Trust in 2008 as a Locum Physiologist and she enjoyed the people and the environment, she said the interaction between staff members highlighted the mutual respect people had for one another. In 2012 the second Cath Lab opened, and the number of Consultants increased. Some were first time consultants and the atmosphere changed which Ms Irvine put down to strong personalities. She continued that in 2015 the Primary PCI service launched and the mood in the department changed again.

Ms Irvine highlighted unprofessional behaviours including negative comments being made during stressful situations, the team ceasing to interact and consultant moods being unpredictable as the catalysts for the staff in the department having a feeling of dread.

Mrs Gomes explained to the Board that she wanted the Consultants to understand the impact the behaviours had on staff and she supported staff to send an email detailing how these behaviours made them feel. She also shared the civility video and worked with the culture team in discussions about the importance of respect, professional courtesy and valuing one another. She said she involved the Associate Medical Director of Patient Safety to encourage better behaviours and compassion which for a short time did improve behaviour.

Mrs Gomes explained that the change in behaviour only lasted a short while therefore she spoke to the Responsible Officer (RO) for Consultants who agreed behaviour changes needed to happen. Following discussions, he wrote to the consultants with a consistent message and the team were currently in the 8th week of improved behaviours.

Ms Irvine explained that there was now a team huddle before the arrival of the consultant as well as a patient hand over. She said these had enabled team bonding and made the consultants more approachable. She said the team and Consultants were both supportive of the new approach.

Mrs Gomes commented that the Consultants were living the Trust values and working on building trust and confidence within the team. She was confident the journey would continue and that the collaborative approach had a positive impact and had been effective.

Mrs Schroder congratulated the team on challenging poor behaviours to a positive outcome following a successful process.

Dr Buckle congratulated the team and commented that the RO had a dual role as the person in authority and as a colleague. He said good quality and regular 360 reviews were valuable in highlighting issues. Mr Pounds explained that the 360 reviews for medics were built into the appraisal system. He said the real value was feedback being provided from the Junior Doctors.

Dr Carter asked if the member of staff who raised the initial issue had remained at the Trust. Mrs Gomes explained that the long-term incivility and negative body language had affected the confidence of the member of staff, and they had left the organisation.

Mr Howell commented that an official escalation should have been made. Mrs Gomes explained that this had happened. Mr Armstrong commented that the situation had left the staff feeling the department was not safe. Ms Irvine commented that patients had not been not the centre of attention. Mr Armstrong asked if the department felt safer since the issue had been addressed. Ms Irvine confirmed it was safe, she explained there was an MDT to discuss the procedure which was both educational and confidence building.

The Trust Board **RECEIVED** and **NOTED** the content of the Staff Story.

22/176 CHIEF EXECUTIVE'S REPORT

Mr Sewell-Jones informed the Board that the CQC report had been received following the inspection of Maternity services in October. He said the overall rating for the unit was inadequate due to Safe and Well-Led being rated inadequate as well as Surgery being rated

as inadequate. He said the Trust rating remained as requires improvement. Mr Sewell-Jones explained that as well as the rating the Trust had also received a Section 29A warning notice. He reported that the Trust had submitted the action returns in accordance with the CQC schedule and all actions were on track as they had been underway for some time. Mr Sewell-Jones complimented the staff in the Maternity unit as well as the wider teams for their hard work. He said the patients who had no experience of the service but had bookings would need reassurance and a direct phone line had been connected to provide support. He confirmed the themes were risks of harm rather than instances of harm and he would continue to inform the Board of progress.

Mr Sewell-Jones explained that to date the industrial action had not had a big impact on the Trust however the Junior Doctors strike in March would result in operational challenges and a reduction in the provision of essential services. The consultant body were planning rotas and would deliver care. He said there would be implications for service provision, productivity and costs. Leadership would be provided by the EPRR team.

Mrs McConnell expressed concern that over three days of industrial action there would be fewer medics and asked whether there was a process in place to learn from quality and safety as well as the motivation of people. Dr Chilvers explained that a command-and-control centre would manage the situation and all learning would be recorded. Mr Pounds explained that communication would be critical and a forum for representative groups for Junior Doctors. He said FAQs were being collated to ensure all staff were communicating the same messages.

Mr Sewell-Jones explained that the elective recovery would be impacted by the industrial action. He said NHE England had released a league table and the Trust were 7th out of 168 which was excellent news, he said there was more that could be done for the 18-month breaches.

Mr Sewell-Jones informed the Board that the Cytosponge had been discussed at a regional specialist collaborative and the Trust had completed 1000 procedures to become the single largest site for this process. He said the commitment and passion of the lead consultant had made a significant impact.

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

22/177 BOARD ASSURANCE FRAMEWORK

Mr Dalton explained that four red risks remained which would be

influenced by external factors. He asked the Board whether the risks were at a point to reduce to a score of 9. Mrs McConnell commented that she believed that the score should remain at 12 due to the alignment with one of the strategic risks and work still being required on a strategic workforce plan and highlighted ensuring staff were in the right places as the issue rather than a pipeline of staff.

The Board **RECEIVED** and **NOTED** the Board Assurance Framework. The Board **AGREED** the rating should remain at 12.

STRATEGY AND CULTURE REPORTS

22/178 STRATEGIC TRANSFORMATION UPDATE

Ms Marwood informed the Board that care closer to home was a PLACE task and finish group that used population health data to target high intensity users across the healthcare system. She said the group was supporting collaborative working and the sharing of expertise and support. A local GP practice was piloting and was sharing data and intelligence.

Ms Marwood explained that Hospital at Home had achieved some high-profile success and work was underway to normalise the service and build it in earlier into the pathway. She said it needed to become standard practice for clinicians as it transferred into business as usual. A system within NerveCentre had been developed for referrals which would impact the numbers. She said the programme was moving towards business as usual.

Ms Marwood explained that the integrated heart failure service pilot was using pump-primed funding from NHS England for earlier intervention, new technology and partnership collaboration.

Mrs Schroder asked about the red on the KPIs. Ms Marwood explained that Hospital at Home processes were in a position of returning to normal and there was an improved referral process. There was discussion whether the criteria led discharge KPIs were correct and there was a significant ambition to change discharge times. She said there was slow progress to see improvement. The compliance against the SOP was re-audited, in December the compliance was 23% and it had increased to 68% and this should reflect on the time to discharge in time. Mrs Murphy explained that there had been progress and staff had been trained successfully. She said with support from the speciality doctors the success would increase, she said it had been embedded into ENT and the Trust was the only one in the East of England to have achieved this.

Mr Sewell-Jones commented that the actions needed to deliver what was required. He said there was a partner meeting about care closer to home that highlighted structures not being in place. He

said the Hospital at Home service the Trust was delivering was seen as an exemplar in terms of numbers of referrals by the region. Mrs Schroder commented that it was these areas that must remain a focus.

Mrs McConnell asked if the sustainability impact had been considered on the closer to home project and she would like to see the "green" impact embedded into the plan.

The Board **RECEIVED** and **NOTED** the Strategic Transformation update.

22/179 PEOPLE AND WORKFORCE STRATEGY ANNUAL PROGRESS REPORT

Mr Pounds informed the Board that the strategy launched in January 2020 and had withstood a lot of changes. It had been reviewed and strengthened in the last 12 months. He said the National People Strategy had also launched against which the Trust strategy had been aligned.

Mr Pounds explained that the values charter had been a focus of attention and it was important for the values to cover the whole organisation.

Mr Pounds highlighted successes around recruitment and growth particularly in relation to nursing and doctors. He said the Enquire Service provided faster and easier access to information, the ENH Academy and central portal, Grow Together, leadership programmes and the Here for You service were all recent improvements.

Mrs Schroder asked for a Workforce plan that covered the next five to ten years. She said this would support whether the Trust was making progress and had the right people in the right place Mr Pounds informed the Board that the national team had started this work and there was now a 4-year look forward.

Dr Carter asked about the pastoral care available when recruiting from overseas and asked how many of these staff stayed. Mr Pounds explained that retention of overseas staff was excellent, and the team carried out more extension to visas after three years.

Mrs McConnell asked about appraisal rates as it appeared that a third of staff had not had an appraisal and were steps being taken to address this. Mr Pounds explained that this would be highlighted in the staff survey. He said the Trust had an expectation that people would be accountable for their own appraisal.

Ms Moore commented on the increase in mandatory training, she said appraisals were increasing but below where they should be,

and all teams were encouraging a fast recovery.

The Board **RECEIVED** and **NOTED** the People and Workforce Strategy Annual Progress Report.

22/180 GENDER PAY GAP

Mr Pounds explained there was a gap between the average pay for males and females. He said the workforce was largely female and year on year the gap was reducing. He said for the higher paid jobs there was a higher proportion of men and broken down by staff group there were challenges in admin and clerical and medical and dental. Mr Pounds informed the Board that nursing and midwifery and AHP's pay gap was in favour of female staff.

Mr Pounds informed the Board that the actions would be around engagement and ensuring the right people were having conversations, flexible working, recruitment and selection, policy on application of salary and clinical excellence awards.

Mrs Schroder commented that the clinical excellence awards were used as a performance tool and they should reflect staff going above and beyond their duties. She said they should reflect good performance within the Trust.

Ms Moore commented on the ethnicity pay gap and said the comparison across the region as well as the year-on-year data highlighted the Trust being in a positive position.

Mr Sewell-Jones commented that female doctors in training and by age was an interesting factor. He commented on how much could be influenced on the age profile as those closer to retirement are likely to be earning more. Dr Chilvers commented that making employment attractive to everyone would take several years.

Ms Davies commented that a communications plan highlighting departments such as Estates and Facilities for the number of senior women in post would be positive messaging.

The Board **RECEIVED** and **NOTED** the Gender Pay Gap.

ASSURANCE AND GOVERNANCE REPORTS

22/181 CQC MATERNITY SERVICES REVIEW

Mrs Murphy highlighted all actions for the section 29A notice were on track for completion in April 2023. She said it would be a challenging few weeks but good systems would be in place.

Mrs Murphy informed the Board that throughout February the views of women had been captured in real-time. She said all five questions would be available via a QR code publicised across the maternity unit to provide local intelligence ahead of the next national maternity

survey.

Mrs Murphy explained that mock CQC inspections had been planned and the head of safeguarding from the ICS would be in the unit to review processes. She said the maternity service was moving in a different direction, the team had stepped-up and were embedding actions as business as usual. EBME checks of equipment had been done and reduced the list of over 700 down to 80 which had not been aligned.

Mrs Murphy informed the Board that the first call of the national maternity support team would be on 6th March 2023.

Ms Moore thanked Mrs Murphy for the scrutiny over the friends and partners. She said the maternity indicator would add benefits for efficiency and satisfaction across the board.

Mr Silver asked about the actions being embedded into business as usual and whether these would move the rating from inadequate to good. He asked for assurance that the processes and systems had embedded sufficiently to ensure the unit didn't deteriorate in the future. Mrs Murphy explained that it had been vital to embed the daily working processes within the senior team, she said there would be a twice-yearly mock inspection of the unit to ensure the new standards were maintained.

The Board **RECEIVED** and **NOTED** the CQC Maternity Services Review.

22/182 RISK STRATEGY

Mrs Murphy explained that the risk strategy had three documents condensed into one. She explained that the strategy would be brought to life by a series of workshops and would be managed through the Risk Management Group.

Mrs Murphy confirmed to the Board that the Risk Strategy had been approved by the Audit and Risk Committee at the meeting held on 17 January 2023.

Mrs McConnell referred to a line that noted a Council of Governors and asked that it be removed as the Trust didn't have Governors.

The Board **RECEIVED**, **NOTED** and **APPROVED** the Risk Strategy.

PERFORMANCE REPORTS

22/183 INTEGRATED PERFORMANCE REPORT

Mr Armstrong explained to the Board that the IPR was scrutinised and discussed in detail at the Board Committee meetings.

Mrs Murphy informed the Board there was a clear focus on learning

from serious incidents and improved reporting. She said the IPC threshold of 69 had been reached however ten cases were being appealed. She said E.coli had increased to 48 against a target of 46, one of these was community acquired, there were no major increases in Covid as a primary diagnosis.

Mrs Murphy explained that there was slow progress in the improvement in complaints and highlighted Unplanned Care as the most significant area. She said discharge summaries were progressing, but Paediatrics remained low.

Mrs Murphy informed the Board that the VTE process had been embedded into NerveCentre which would allow daily reporting to support the VTE compliance.

Mr Pounds informed the Board that there was a lot of work underway in relation to medical recruitment, there were 45 in the pipeline of which 20 were international.

Mr Pounds explained that the induction and onboarding process made a big difference to the new employee experience. He said the induction day would be replaced by a values day alongside socialising and pastoral care to support new members of staff.

Ms Davies informed the Board that ambulance handover times had improved significantly with the median more than halved. She said with the increased capacity in SDEC, escalation processes and pull for safety had all contributed to drive improvement.

Ms Davies explained that there had been good progress on the 78 week waits and the Trust were ahead of the trajectory. She said the impending industrial action would impact on all areas.

Mr Armstrong informed the Board that for month 10 the Trust was reporting a £5.6m deficit which had been formally confirmed with NHS England. He said the end of year deficit was forecast at £8m. He said work would continue with system colleagues to manage the finances and to build a sustainable finance plan for the new financial year.

The Board **RECEIVED** and **NOTED** the Integrated Performance Report for month 10.

22/184 SYSTEM PERFORMANCE REPORT

Mr Armstrong explained that the System produced a series of reports and additional information could be considered at future meetings. He said the primary area of performance related to age and mental health.

Mr Armstrong explained that the areas of focus would be elective performance, theatre utilisation and compared to other colleagues

the Trust performed well.

Ms Davies highlighted that the Urgent and Emergency Care data in the report was out of date as it was commentating on November and there had been significant improvements in recent weeks.

Mrs Schroder asked Mr Dalton to follow up the ICB board meeting report. — Head of Corporate Governance

Dr Carter commented on mental health patients out of area and the number of bed days. He said the impact on the Trust due to a lack of movement on beds was considerable. Mrs Schroder commented that it was a whole system issue. Mr Sewell-Jones explained that a new facility was awaiting funding.

The Board **RECEIVED** and **NOTED** the System Performance Report.

BOARD COMMITTEE REPORTS:

22/185 FINANCE, PERFORMANCE AND PLANNING COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Finance, Performance and Planning Committee meetings held on:

24 January 2023

21 February 2023

22/186 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Quality and Safety Committee meetings held on:

25 January 2023

22 February 2023

22/187 AUDIT COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary report from the Audit Committee meeting held on 17 January 2023.

22/188 PEOPLE COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary report of the People Committee meeting held on 14 February 2023.

22/189 ANNUAL CYCLE

The Board **RECEIVED** and **NOTED** the latest version of the Annual Cycle.

22/190 ANY OTHER BUSINESS

No other business was raised.

22/191 DATE OF NEXT MEETING

The next meeting of the Trust Board will be on 1 May 2023.

Ellen Schroder
Trust Chair
March 2023

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

Agenda item: 5

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO 5 MAY 2023

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date

East and North Hertfordshire NHS Trust

Chief Executive's Report

May 2023

New Medical Director

We are delighted to welcome Dr Justin Daniels to the Trust as our Medical Director.

Justin is a Consultant Paediatrician and has a wealth of experience most recently as Deputy Chief Medical Officer at Barking, Havering and Redbridge University Hospitals NHS Trust and before that held various roles at North Middlesex University Hospital NHS Trust for 18 years

Dr Michael Chilvers' is returning to his clinical duties in the Trust as a Consultant Anaesthetist. We'd like to thank Mike for his leadership over the last 5 years and we are delighted that he's decided to continue his clinical work with us.

Industrial Action

Industrial action has been a significant feature of recent weeks, most notably the days immediately following the Easter Holiday weekend when junior doctors took industrial action. This was a challenging period and required significant planning in the lead up to Easter.

I'd like to thank our consultants and other clinical staff for changing roles and working patterns to ensure that we were able to provide urgent and emergency care as well as maintaining the planned activity where we were able. Also, I'd like to thank the many, perhaps less recognised, staff who had the responsibility for the detailed planning and contacting of patients to cancel and rearrange appointments.

Unfortunately, despite the efforts of staff the consequence was a significant number of patients having their appointments cancelled. During the four days of the action 254 planned procedures and 1,832 outpatient appointments had to be cancelled. I'd like to apologise to all those affected, and we will seek to rebook appointments as soon as possible.

Entonox

There have been reports in the media about some NHS trusts suspending the use of Entonox over concerns about how levels of waste gas might affect staff and service users. Entonox is a mixture of nitrous oxide and air. Known more commonly as gas and air, it can be used as pain relief for women in labour.

We have conducted tests to monitor the Entonox levels within our services in the Maternity Unit, and within our Emergency Department (including resus areas and paediatrics).

Our Trust's ventilation systems, as well as all Entonox outlets have been rigorously tested and found to be safe. The monitored levels are significantly lower than the Workplace Exposure Limit (WEL) of 100ppm. The highest recorded reading for an 8-hour time-weighted average working period was just 0.81ppm.

Adam Sewell-Jones
Chief Executive

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	9
Report title	**Board Assurance Framework (BAF) & 2023-24 BAF**			**Meeting Date**	3 May 2023
Presenter	Stuart Dalton, Head of Corporate Governance				
Author	Stuart Dalton, Head of Corporate Governance				
Responsible Director	Martin Armstrong, Deputy CEO			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

The paper presents the proposed 2023-24 BAF in addition to the regular BAF progress report.

2023-24 BAF

The following changes for the 2023-24 BAF were identified at the April Board Seminar:

- New Risk 6: If the desired autonomy with appropriate accountability approach is not achieved. Then the Trust will continue to face the same structural and culture challenges. Resulting in the Trust being unable to deliver needed changes and improvements.
- New Risk 10 (proposed to replace existing Risk 10): If the necessary digital transformation improvements are not prioritised, funded or delivered. Then the Trust will lack the digital means to deliver its plans including using obsolete legacy systems that are unsupportable. Resulting in 1) not delivering transformation plans that are crucial to improving efficacy and productivity 2) not achieving the nationally mandated minimum digital foundations
- Wording changes were suggested to some of the existing BAF risks at the Seminar which are shown as tracked changes (see Appendix 1)

The Board is asked to confirm if it wants any changes to the proposed 2023-24 BAF.

BAF progress report

The BAF risks are enclosed for review (tracked changes show updates since the last Board review), including a Risks Summary, a Heat Map and the Trust's strategic priorities (the 23-24 priorities will be enclosed with future reports, once Board-approved). Key points are:

- There are no risk score changes proposed.
- Over the course of 22-23 BAF year, six risks have not seen their score change. Hence the importance of agreeing a date for the target score for the 23-24 BAF to help the Board assess if progress is on track and mitigations are effective.
- Seven risks of the 11 risks were red-rated (scoring 15 and above) during the last year. Four risks remain red-rated. Risk 8 (performance and flow) started scored 12 and increased and has stayed at 16. Risk 3 (financial constraints) started at 16 and has increased to 20, which is the only risk rated as high as 20 on the BAF. Risk 5

(Culture, leadership and engagement) and Risk 7 (Immature place and system collaborative processes and culture) were scored 16 a year ago and remain scored 16. Three red-rated risks have reduced risk scores through effective mitigation work.
Impact: where significant implication(s) need highlighting
Covered above
Risk: *Please specify any links to the BAF or Risk Register*
N/A - BAF
Report previously considered by & date(s):
The 23-24 BAF was brainstormed at the 5 April Board Seminar and the proposed risks circulated for comment to Board members on 17 April. Since the BAF was reviewed at the last Board, all the BAF risks have been reviewed by their respective lead committees.

Recommendation	The Board is asked to: • Endorse the 2023-24 BAF • Note the BAF update

To be trusted to provide consistently outstanding care and exemplary service

APPENDIX 1

2023-24 BAF RISK DESCRIPTIONS

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**		Risk score 12
Strategic Risk No.1: **Workforce requirements**		
If we fail to ~~recruit and retain sufficient~~have high-quality staff in the right places with effective rostering and ratios	***Then*** we will not be able to deliver the needs of the population and standard of care that are required	***Resulting in*** poor performance, poor patient experience; failure to ensure the best possible health outcomes and quality of life; and a loss of trust

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**		Risk score 12
Strategic Risk No.2: **Population/stakeholder ~~expectations~~needs**		
If we do not address health inequalities or meet the expectations of patients and other stakeholders~~, in the context of unprecedented backlogs~~	***Then*** population/stakeholder outcomes will suffer and dissatisfaction will grow	***Resulting in*** loss of trust, loss of funding opportunities and regulatory censure, poorer outcomes

NO CHANGES

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**		Risk score 20
Strategic Risk No.3: **Financial constraints and efficiencies**		
If costs increase significantly and/or far-reaching financial savings are required, and we do not deliver greater efficiencies	***Then*** we will need to make difficult decisions that could have a negative impact on quality and delivery	***Resulting in*** poorer patient outcomes, longer waiting times; reduced staff morale and reputational damage

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**		Risk score 12
Strategic Risk No.4: **Workforce shortages and skill mix**		
If global and local workforce shortages in certain staff groups persist or increase combined with not having the right skill mix	***Then*** the Trust may not have the required number of staff with the right skills in the right locations	***Resulting in*** a negative work experience for staff due to increased work burden and gaps in skills to deliver services, ultimately affecting patient experience

NO CHANGES

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**		Risk score 16
Strategic Risk No.5: **Culture, leadership and engagement**		
If the culture and leadership is hierarchical and not empowering or compassionate and inclusive and, does not engage or listen to our staff and provide clear priorities and co-ordination	***Then*** staff experience relating to stress, bullying, harassment and discrimination will perpetuate and lead to ambiguity, information overload and staff fatigue.	***Resulting in*** staff disengagement, confused priorities, loss of purpose and low morale plus poorer staff morale and retention and ultimately poorer quality of services and patient outcomes and CQC ratings

NEW

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**			Risk score ?
Strategic Risk No.6: **Autonomy and accountability**			
If the desired autonomy with appropriate accountability approach is not achieved	***Then*** the Trust will continue to face the same structural and culture challenges	***Resulting in*** the Trust being unable to deliver needed changes and improvements.	

NO CHANGES

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**			Risk score 16
Strategic Risk No.7: **Immature place and system collaborative processes and culture**			
If the emerging ICS and place-based models do not develop at pace and we are unable to develop mutually collaborative approaches with partners throughout the system	***Then*** collaboration will stall, and partners will not trust us and vice versa	***Resulting in*** not delivering improved ways of working, missing the opportunities to improve health services and patient outcomes system-working offers; regulatory accountability and not achieving the system financial envelope.	

NO CHANGES

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**			Risk score 16
Strategic Risk No.8: **Performance and flow**			
If we do not achieve the improvements in flow within the Trust and wider system	***Then*** the Trust's key performance targets will not be met	***Resulting in*** increased avoidable Serious Incidents, wider health improvements not being delivered and regulatory censure	

NO CHANGES

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**			Risk score 12
Strategic Risk No.9: Trust and system **financial flows and efficiency**			
If finances do not move around the system in recognition of costs incurred in new models of care	***Then*** our and our partner financial positions will deteriorate	***Resulting*** in the inability to fund planned service delivery and regulatory scrutiny	

NEW

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**			Risk score ?
Strategic Risk No.10: ~~**Technology, systems and processes to support change**~~Digital Transformation			
~~***If*** the necessary digital transformation improvements are not prioritised or delivered~~	~~***Then*** the Trust will lack the digital means to deliver its plans~~	~~***Resulting in*** failing to improve productivity, deliver efficiencies and performance targets and expected standards~~	
If the necessary digital transformation improvements are not prioritised, funded or delivered	***Then*** the Trust will lack the digital means to deliver its plans including using obsolete legacy systems that are unsupportable	***Resulting in*** 1) not delivering transformation plans that are crucial to improving efficacy and productivity 2) not achieving the nationally mandated	

		minimum digital foundations

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**		Risk score 12
Strategic Risk No.11: **Enabling innovation**		
If we do not foster a learning culture where experimentation and questions are encouraged and staff are supported to innovate and ~~do the right thing when mistakes happen~~learn and share	***Then*** there is the risk staff will become disempowered, will not identify solutions, not challenge without fear, not learn from mistakes ~~and managers will hide issues~~ and the culture will be psychologically unsafe.	***Resulting in*** avoidable harm to patients, missed opportunities for improvement, productivity and potential regulatory interventionand a culture of uncivil behaviour and lack of trust amongst staff

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**		Risk score 12
Strategic Risk No.12: **Clinical engagement ~~with change~~**		
If the conditions for clinical engagement with ~~change and~~ best practice and change are not created and fostered	***Then*** we will be unable to make the transformation changes needed at the pace needed	***Resulting in*** not delivering our recovery targets or improved clinical outcomes; not building a financially sustainable business model; and being unable to contribute fully to system-wide ~~improvements~~ transformation

East and North Hertfordshire NHS Trust

BOARD ASSURANCE FRAMEWORK REPORT

Section 1 - Summary

Risk no	Strategic Risk	Lead(s) for this risk	Assurance committee(s)	Current score	Trajectory
Consistently deliver quality standards, targeting health inequalities and involving patients in their care					
1.	**Workforce requirements**	Chief Nurse (Medical Director) (Chief People Officer)	Quality & Safety	12	⟷
2.	**Population/stakeholder expectations**	Chief Nurse (Medical Officer)	Quality & Safety	12	⟷
3.	**Financial constraints**	Chief Financial Officer	Finance, Performance & Planning	20	⟷
Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability					
4.	**Workforce shortages and skills mix**	Chief People Officer	People	12	⟷
5.	***Culture, leadership and engagement***	Chief People Officer	People	16	⟷
6.	*Combined with risk 5*				
Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners					
7.	**Immature place and system collaborative processes and culture**	Deputy Chief Executive (CFO)	Finance, Performance & Planning	16	⟷
8.	**Improving performance and flow**	Chief Operating Officer	Finance, Performance & Planning	16	⟷
9.	**Trust and system financial flows and efficiency**	Chief Financial Officer	Finance, Performance & Planning	12	⟷
Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities					
10.	**Technology, systems and processes to support change**	Director of Transformation	Quality & Safety	12	⟷
11.	**Enabling Innovation**	Director of Transformation	People	12	⟷
12.	**Clinical engagement with change**	Medical Director (Chief Nurse)	Quality & Safety	12	⟷

Section 2 Strategic Risk Heat Map

Current risk scores in **black**
Target risk scores in ***grey***

Impact						
	5				3	
	4			1; 9; 11; 12 3; 7; 12	5; 7; 8	
	3			1; 2; 5; 9; 11	2; 4; 10	
	2			4; 8; 10		
	1					
	I x L	1	2	3	4	5
		Likelihood				

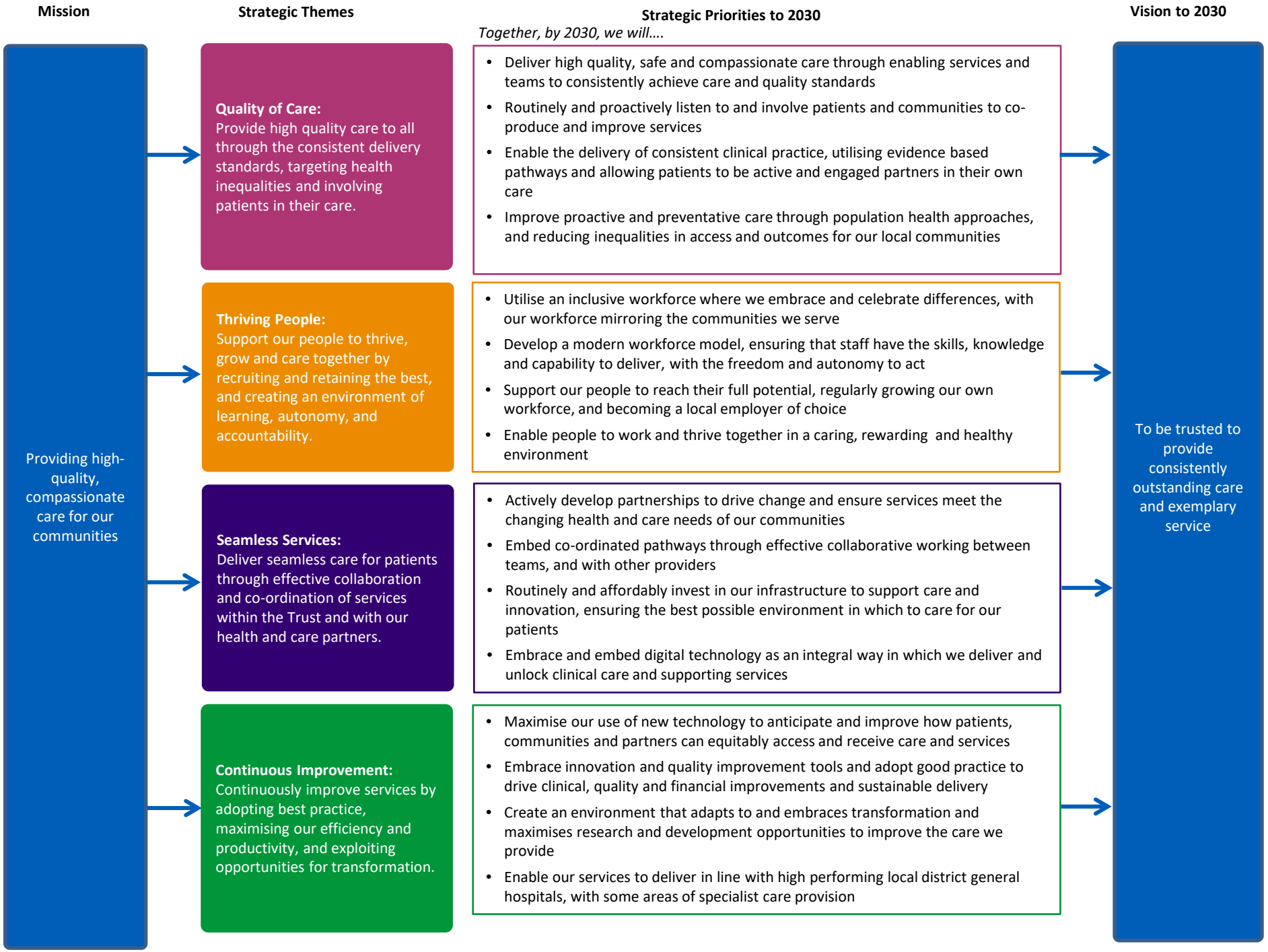
Risk Scoring Guide

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.

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

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

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

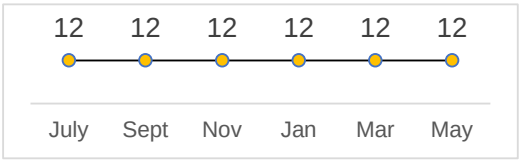

Mission
Strategic Themes
Strategic Priorities to 2030
Together, by 2030, we will….
Vision to 2030
Providing high-quality, compassionate care for our communities
Quality of Care:
Provide high quality care to all through the consistent delivery standards, targeting health inequalities and involving patients in their care.
Deliver high quality, safe and compassionate care through enabling services and teams to consistently achieve care and quality standards
Routinely and proactively listen to and involve patients and communities to co-produce and improve services
Enable the delivery of consistent clinical practice, utilising evidence based pathways and allowing patients to be active and engaged partners in their own care
Improve proactive and preventative care through population health approaches, and reducing inequalities in access and outcomes for our local communities
Thriving People:
Support our people to thrive, grow and care together by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability.
Utilise an inclusive workforce where we embrace and celebrate differences, with our workforce mirroring the communities we serve
Develop a modern workforce model, ensuring that staff have the skills, knowledge and capability to deliver, with the freedom and autonomy to act
Support our people to reach their full potential, regularly growing our own workforce, and becoming a local employer of choice
Enable people to work and thrive together in a caring, rewarding and healthy environment
Seamless Services:
Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our health and care partners.
Actively develop partnerships to drive change and ensure services meet the changing health and care needs of our communities
Embed co-ordinated pathways through effective collaborative working between teams, and with other providers
Routinely and affordably invest in our infrastructure to support care and innovation, ensuring the best possible environment in which to care for our patients
Embrace and embed digital technology as an integral way in which we deliver and unlock clinical care and supporting services
Continuous Improvement:
Continuously improve services by adopting best practice, maximising our efficiency and productivity, and exploiting opportunities for transformation.
Maximise our use of new technology to anticipate and improve how patients, communities and partners can equitably access and receive care and services
Embrace innovation and quality improvement tools and adopt good practice to drive clinical, quality and financial improvements and sustainable delivery
Create an environment that adapts to and embraces transformation and maximises research and development opportunities to improve the care we provide
Enable our services to deliver in line with high performing local district general hospitals, with some areas of specialist care provision
To be trusted to provide consistently outstanding care and exemplary service

Section 3 –Strategic Risks

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**			Risk score 12
Strategic Risk No.1: **Workforce requirements**			
If we fail to recruit and retain sufficient high-quality staff in the right places	***Then*** we will not be able to deliver the needs of the population and standard of care that are required	***Resulting in*** poor performance, poor patient experience; failure to ensure the best possible health outcomes and quality of life; and a loss of trust	

	Impact	Likelihood	Score
Inherent	4	4	16
Current	4	3	12
Target	4	2	8

Risk Trend



Risk Lead	Chief Nurse (Medical Director) (Chief People Officer)	Assurance committee	Quality and Safety

Controls	Assurances reported to Board and committees
Strategies and Plans • Clinical Strategy 2022-2030 • People Strategy • Annual Divisional workforce plans • Thematic review of complaints relating to staffing **Operational Systems and Resources** • Local recruitment and retention plans • Detailed establishment reviews across Nov/Dec 2022 • International recruitment plans • Training needs analysis reviews (capability building) • Fill rates and reviews • GROW appraisal and talent system weekly review via hot topics for nursing and midwifery/AHPs • Apprenticeship schemes • Change policy and toolkit • Pre and post reg training programs **Governance & Performance Management Structures** • Accountability and Review Meetings (ARM) • People Committee	**Internal Committee-level assurances** • Integrated performance report key indicators • Deep Dive recruitment briefs and reviews reports • Freedom to Speak up prevalence thematic analysis reports • Positive leadership rounds (January 2023) • Board members walk rounds to be piloted with positive leadership rounds (April 2023) • Deep dives for each division to establish staffing plans/budgeted WTE – ED, maternity and planned care. Check and challenge sessions for on rota staffing reviews due March 2023. **Third line (external) assurances** • Staff survey results • External benchmarking with Integrated Care Partnership, Integrated Care Board and other partners • Ad hoc feedback: Health Education England / Professional Bodies / Academic body (pre and post reg) partners feedback • Care Quality Commission engagements session feedback reports • Patient feedback (national) survey
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
No substantive care support worker development programme	Redesign of service delivery pathways and development of new roles including 'grow your own' skills/talent - *by end of ~~Q4 2022/23~~Q1 2023/24* - Heath care support worker care certificate programme in progress at onboard phase. BEECH course now in progress for CSW management of the deteriorating patient

Recruitment and retention plans required for professional groups with identified high vacancy rates, e.g. pharmacy, administration	• ~~Review of establishment in Electronic Staff Record to confirm baseline staffing position - *by end of Q4 2022/23. Establishment review went to Board*~~ • Ongoing review of establishments in progress in relation to shift patterns and budget alignment *due by Q1 2023/24.* • E-roster establishment review ongoing – by end Q2 23/24 • ~~Specialty specific Recruitment and retention plans - *by end of Q4 2022/23*~~ Plans to continue collaboration with the ICS for international nurse recruitment for 22/23- bid successful March 2023, recruitment plans TBC • Virtual training sessions and drop in events continue to take place in April and May 2023 and are set to continue during the appraisal cycle to support GROW conversations • Scoping with university to deliver ward managers development programme– aim to deliver Q4 2023/24 • CPO and CNO supporting deep dives in safer staffing across ~~*October 2022 –*~~CNO safer staffing paper ~~*due to go*~~was presented to TMG March 2023 and QSC April 2023.
National and local cost of living and employment picture, which may make recruitment more challenging	National workforce strategy to be published by end of 2023. Support for staff with cost-of-living bundle of interventions already in place (community shop; blue light card refund; discounted vouchers, discounted fuel & increased excess mileage rate, lunch vouchers etc) – keep under review

Current Performance - Highlights

The following points are highlighted from the Integrated Performance Report:

- Successful bids with ICS for international nurse recruitment for 23/24
- Good governance actions in progress to review reporting structures, and clarity of roles and responsibilities.
- Development in system for GROW conversations completed and new cycle ~~commences from~~has started in April 2023
- Refreshed and reviewed induction programme in place for new joiners to ENHT with clearer development and work continues to enable early access to systems for e-learning to achieve day 1 ready in the future
- Developmental programme for ward manager with support of University
- New roles and pathways under development e.g. physician associates, health care support worker pathways, nurse prescribing roles

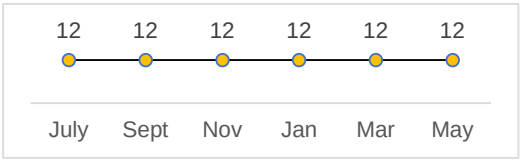
Associated Risks on the Board Risk Register

Risk no.	Description	Current score
	To be added once Corporate Risk Register work is complete (this applies to all the BAF risks)	

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**		Risk score 12
Strategic Risk No.2: **Population/stakeholder expectations**		
If we do not meet the expectations of patients and other stakeholders, in the context of unprecedented backlogs	***Then*** population/stakeholder dissatisfaction will grow	***Resulting in*** loss of trust, loss of funding opportunities and regulatory censure, poorer outcomes

	Impact	Likelihood	Score
Inherent	4	4	16
Current	3	4	12
Target	3	3	9

Risk Trend



Risk Lead	Chief Nurse (Chief Medical Officer)	Assurance committee	Quality & Safety Committee

Controls	Assurances reported to Board and committees
Partnership Arrangements • NHSE/I Recovery operational plan • Integrated Care Board agreements • Health watch. March 2023 maternity engagement focus • Provider collaborative • Elective HUB development / Community diagnostic HUB • Maternity Voices Partnership • Maternity Improvement Senate. Established and in place **Strategies and Plans** • Quality Strategy • National Patient Safety Strategy • National patient Experience Strategy **Systems and Resources** • QlikView Quality dashboards • Quality Oversight System 'EnHance'. EnHance being implemented **Governance and Performance Management Structures** • Accountability review meetings • Patient and Carer Experience Group • Patient initiated Follow Up programme. Pilot follow up planned for SDEC. • Risk management group **Quality Management Processes** • Clinical harm reviews - cancer and non-cancer • Learning from incidents • Triangulation of incidents and complaints at divisional level. Triumvirates asked to present triangulation work. April 2023 QSC • PSIRF discovery phase to scope PSIRF plan • Model hospital information on service line and specialty standards **Sharing best practice** Transformation programmes, specifically: • Discharge collaborative	**Internal Committee-level assurances** • Elective recovery programme escalation reports • Cancer board escalation reports • Accountability Review Meetings escalation reports • Integrated performance reports to Board/ Committees • Executive Programme board escalation reports Sub Board Committees – assurance reports to board: • Patient and Carer Experience • Finance and Performance Committee • Audit and Risk Committee **Third line (external) assurances** • NHS Annual specialty patient surveys (ED, cancer) reports • NHS Friends and Family survey results • Care Quality Commission assessment reports • HSIB reviews/reports • NHSE regulator review meeting escalation reports • Peer reviews of selected services • National patient survey

• Complaints transformation • Outpatient and theatre transformation • ICS transformation programme	
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Poor timelines in responding to concerns increasing	Complaints transformation programme – *already in progress*
• Unwarranted variation across specialty booking Follow Up processes • Waiting list initiative payment model	• ~~Establish safety~~Transformation programme is in place to support improvement ~~learning collaborative~~ in FUP processes • PSIRF improvement priorities shall be launched by end of ~~Q3 2022/23~~Q2 2023/24 *Update: some learning collaboratives in progress. PSIRF to be signed off by Board by Sept 23* • Transition to new a learning from incidents framework - *by end of Q4 2022/23 Update: Moved to ENHance. PSIRF to be signed off by Board by Sept 23* • Pro-active Communication plan with public and partners *– already in progress Director of Communications leading on this due Spring 2023. JDs and adverts for patient safety partners.* • ~~Moving beyond safe programme for clinical matron. ENHT matrons~~Getting to Good – service level governance development programme ~~in planning phase aimQ3/4~~shall be designed and delivered by Q2 2023-~~/24~~
Unwarranted variation on Clinical Harm Review – non-cancer backlogs	Business case for a digital solution - *in progress for >52weeks incidents. Clinical harm reviews include proactively contacting/ texting all patients to assess need for waiting list. The 2nd phase of the project is to text clinical harm review questions, this phase in in planning stage.*
Clearer processes required for harm reviews relating to time waited for procedure	Implement and embed quality assurance framework - *by end of Q4 2022/23 as above.*
Delayed in patient information of non-cancer diagnosis	Improvement priorities focusing on clinical outcome letter processes, to be embedded by end of Since the introduction of the negative result letters and CNS telephone appointments the position has improved and work continues to work with the tumour Leads and operational teams to improve the patient pathway.
Referral To Treatment (RTT) TIER 1 rating due to long waiting times status	Implementation of intensive recovery plan *by end of Q4 2022/23. [Awaiting update]*
Patient, public, stakeholder and partner engagement	Engagement strategy to be approved by the Board by Oct 23 Maternity community engagement session being planned, due to Q2 2023/24 Patient safety partner advert now live, aim to recruit and place by Q2 2023/24
Family liaison in patient safety incidents/bereavement	Planning phase in progress, due for completion Sept 2023
Quality governance assurance framework re-design (no surprises)	Draft plan in place, stakeholder engagement and sign off due ~~April~~May 2023
Patient-centred decision-making	Patient co-design and engagement plans in progress, scoping underway to imbed in patient co-design framework, aim Sept 2023

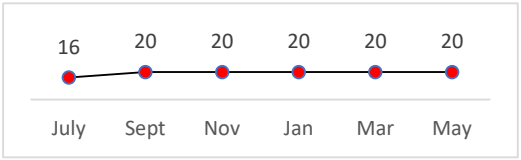
Current Performance - Highlights
The following points are highlighted from the IPR most recent Board report:

- On average 94% of complaints are acknowledged within 3 working days
- ~~On average 75% of complaint responses are~~Overall complaints responded to within agreed timeframe remain below agreed target and a priority for improvement

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**		**Risk score 20**
Strategic Risk No.3: **Financial constraints and efficiencies**		
If costs increase significantly and/or far-reaching financial savings are required, and we do not deliver greater efficiencies	***Then*** we will need to make difficult decisions that could have a negative impact on quality and delivery	***Resulting in*** poorer patient outcomes, longer waiting times; reduced staff morale and reputational damage

	Impact	Likelihood	Score
Inherent	5	4	20
Current	5	4	20
Target	4	3	12

Risk Trend



Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Approved 22/23 Revenue, Capital, CIP & Activity Plan **Operational Systems and Resources** • Financial Reporting Systems – Finance Qlikview Universe • Detailed monthly CIP performance reporting • Forecast Outturn Model and Monthly Reports • Detailed bridge analysis of deficit drivers **Governance & Performance Management Structures** • Monthly FPPC & Exec Committee Reporting • Monthly Divisional Finance Boards meetings • Monthly Capital Review Group • Financial Reset Steering Group – commences Nov-22 • Monthly cost-centre / budget holder meetings • Bi-weekly ICS Director of Finance meetings • Ratified SFI's and SO's, Counter Fraud Policy • Consolidated ICS Procurement Service & Governance • Outturn Variance Protocol implemented (Jan) • Triple Lock Investment Review protocol (Dec)	**First and second line (internal) assurances)** • Monthly Finance Report / Key Metrics to FPPC • Financial Reset Programme proposed to and supported by the Trust Board (07/09/22). Monitoring through Board, FPPC, TMG & Financial Reset Steering Group. **Third line (external) assurances** • 22/23 Financial plan submitted to and approved by NHSE • Monthly financial reporting to NHSE & HWE System • Finance Outturn and Reset Programme reviewed by ICS • External / Internal audit review of key financial systems and processes • National review of financial sustainability performance (complete in Q3) • Model Hospital / GIRFT / Use of Resources benchmarking
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Failure to deliver CIP savings at the level planned, placing financial pressure on the Trust and its system partners • Failure to remove COVID related cost investments in parallel with reductions in COVID income funding • The Trust is forecast to deliver an outturn deficit of £6.9m at year end.	• CIP Design and Delivery Framework approved at TMG (Oct) • CIP opportunities workshop (December) • Application of D&C and opportunities in 23/24 CIP programme work up in Feb and March. • Monthly financial reset meetings with divisions and Financial Reset Steering Group (In Place)
• Risk of non-payment of ERF overperformance by ICB and NHSE	• Outturn ERF positions agreed with both HWE ICS and Specialist Commissioning, agreed in YE position.
• Significant overspend against elements of the Trust's workforce establishment.	• Financial Reset – 'Medical Staffing' review to focus on this significant overspending area, follow up report to FPPC in February.
• Ratification of Medium-Term financial plan (MTFP) and assumptions – both Trust & ICS, triangulation with clinical strategy and improvement / transformation projects.	• Development and implementation of MTFP planning framework with ICS partner organisations. Ongoing work programme extended by HWE ICS DoFs into 23/24

• Significant reductions in Trust productivity in 22/23 vs pre-pandemic levels. Significant increases in staff volumes and costs not related to activity change.	• The Trust has undertaken extensive run rate and associated bridge analysis. This has framed areas for review and restatement for 23/24. This is formalized in a specific strand of budget setting activity. ~~Delivery in February & March~~'Establishment Growth' review sessions during April.

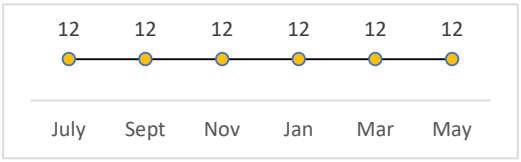
Current Performance – Highlights
The following points are highlighted from the Integrated Performance Report: • Year ~~to date deficit~~End Outturn Position of £~~4.9m~~6.1m • Reliance upon non recurrent reserves to support plan achievement year to date • £~~5.7m~~6.8m YTD slippage against agreed CIP programme • Medical staffing budgets overspend of £~~4.1m~~6.3m YTD

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**		Risk score 12
Strategic Risk No.4: **Workforce shortages and skill mix**		
If global and local workforce shortages in certain staff groups persist or increase combined with not having the right skill mix	***Then*** the Trust may not have the required number of staff with the right skills in the right locations	***Resulting in*** a negative work experience for staff due to increased work burden and gaps in skills to deliver services

	Impact	Likelihood	Score
Inherent	4	4	16
Current	3	4	12
Target	2	3	6

Risk Trend



Risk Lead	Chief People Officer	Assurance committee	People Committee

Controls	Assurances reported to Board and committees
Strategies and Plans • Data accuracy between ESR and finance systems • Clinical Strategy 2022-2030 • People Strategy • Annual Divisional workforce plans and local Skill mix reviews • GROW and Succession plans • Tailored approach to nursing and medical and administration hotspots, with UK based campaigns supported by international recruitment plans **Learning and Development** • Apprenticeship schemes • Leader and Manager Development programmes **Recruitment and Retention** • Workforce Plans • NHSP and international recruitment • Various return to work schemes e.g. retire and return • Drive for 5% - recruitment and retention steering group • ICS retention pathfinders working groups **Staff Engagement & Wellbeing** • Thank you and engagement interventions • Staff Survey • Absence and referral rates • Take up of wellbeing services **Governance & Performance Management Structures** • Medical establishment oversight working group • Clinical oversight working group • Recruitment and retention group • Workforce reports – time to hire, pipeline reports • Executive Programme Board	**First and second line (internal) assurance** • IPR – to board and People Committee, including vacancy and turnover rates • WDES/WRES reports - to board and People Committee • Recruitment and Retention deep dives and reports – People Committee, ARM, Divisional Boards • Deep dives with focus on specific workforce areas **Third Line (external) assurances** • Equality data for workforce (WRES/WDES) • Staff survey results
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps

• How we prioritise delivery • Capacity to deliver scale of changes alongside day to day service delivery e.g. scaling up agenda 'v' local changes to improve services, rely on same resources to deliver both.	• Prioritisation of programmes through board and agreed by executives in line with annual planning cycle • Improving workforce plans at divisional levels to inform prioritisation of plans to Board in line with the annual planning cycle (planning cycle Sept-March) • Demand and capacity planning sessions support and inform the above
• Engagement and motivation to enable changes to be embedded e.g. where a change may mean we no longer deliver something ourselves and its delivered by others	• People change review report and updates which go regularly to divisional boards and sight being introduced to TMG on a regular basis (quarterly) • Support and development to managers leading change and supporting staff through change – scheduled regular development sessions throughout the year planned
• Competition for funding and resources across budgets to enable change at scale to happen	• Funding for large scale change to backfill release of experts to input early • Prioritisation agreed as above • Funding flows to support delivery requirements
• Capacity of key clinicians and senior leaders to work on the areas of change due to conflicting priorities	• Agreed protected time at outset of programme of change as an agreed priority – will require Programme Management Board and TMG sign-off
• Requirement for national and regional NHS workforce strategies as ENHT is dependent on these to ensure sustainable delivery of workforce changes	• Government commitment to produce NHS workforce strategy by Apr 24 • ICS workforce strategy produced January 23

Current Performance - Highlights

The following key performance indicators are highlighted from Integrated Performance Report:

- Plans to continue collaboration with the ICS for international nurse recruitment for 23/24
- ~~Virtual training sessions and drop in events continue to take place in April and are set to continue during the appraisal cycle to support~~Development in system for GROW conversations completed and new cycle commences from April 2023
- Refreshed and reviewed induction programme in place for new joiners to ENHT with clearer development and work continues to enable early access to systems for e-learning to achieve day 1 ready in the future
- New roles and pathways under development e.g. physician associates, health care support worker pathways, nurse prescribing roles.

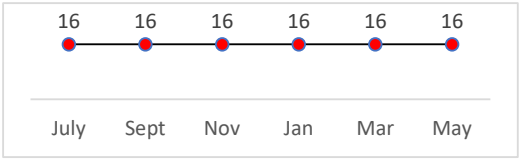
Associated Risks on the Board Risk Register

Risk no.	Description	Current score
6359	Risk that the failure to achieve the Trust target for staff appraisals of 90% compliance will have an adverse impact on staff engagement and on the effective line management of staff.	12
6848	There is a risk that the Trust will fail to develop an effective workforce plan and workforce model for each service that takes account of new/different ways of working and will also fail to make best use of the existing talent pool through developing staff to their full potential and enabling flexible working arrangements.	16

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**			Risk score 16
Strategic Risk No.5: **Culture, leadership and engagement**			
If the culture and leadership is hierarchical and not empowering or compassionate and inclusive and, does not engage or listen to our staff and provide clear priorities and co-ordination	***Then*** staff experience relating to stress, bullying, harassment and discrimination will perpetuate and lead to ambiguity, information overload and staff fatigue.	***Resulting in*** staff disengagement, confused priorities, loss of purpose and low morale plus poorer staff morale and retention and ultimately poorer quality of services and patient outcomes and CQC ratings	

	Impact	Likelihood	Score
Inherent	4	4	16
Current	4	4	16
Target	3	3	9

Risk Trend



Risk Lead	Chief People Officer	Assurance committee	People Committee

Controls	Assurances reported to Board and committees
Strategies and Plans • People Strategy • ENHT Values • People policy reviews • Speak Up approaches • EDI Strategy • Leadership Development Plans **Learning and Development** • Core skill and knowledge programmes (management and Leadership) • Healthy Leadership, care support pyramid • Civility Matters • Mentoring and coaching programmes • Mandatory learning around inclusion, management and development of people • Speak up training **Recruitment and Retention** • Values assessment undertaken at application stage for senior roles and in shortlisting criteria • Pulse surveys • Feedback through local induction processes • Grievance and raising concerns policy and guidance **Staff Engagement & Wellbeing** • Core offer of support available linked to financial, physical, mental, spiritual and social wellbeing for all staff • Annual days to raise awareness of specific topics • Staff networks /Freedom To Speak Up/ Meet the Chief Executive • We have submitted our SEQOHS application for Health@Work services • Internal communications - all staff briefing, in brief and newsletter **Governance & Performance Management Structures** • People Committee, staff side, Local Negotiating Committee	**First and second line (internal) assurance** • Regular reports on progress against People Strategy • IPR **Third Line (external) assurances** • National staff survey results • WRES/WDES • Published equality data

• Divisional boards • Grow together reviews and talent forums • Staff networks	
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Capacity to undertake support and development in identified areas to improve leadership practice and engagement • Challenges in the level of organisational engagement across ENHT to make things happen and embed sustainable change	• Prioritise approaches for service areas and deliver development work by end of Q4. • Staff survey action plans support improvements happening locally and results are used to identify priority areas and specific support to low score areas • Cultural development work continues with senior leadership team
• Capacity to release staff and leaders to participate in development alongside day-to-day priorities	• Creative delivery and support to enable release and participation e.g. protected time; forward planned events and team talks • Dedicated agreement organisationally of time to develop e.g. to complete mandatory training
• Ability to resolve staff complaints quickly and easily	• People Policy reviews will be complete by March 2023 and a rolling programme for training managers in investigation, reports and hosting challenging conversations will follow during 2023/24 – on track
• Investment and support levels organisationally for EDI programmes and resources restricts progress	• EDI strategy produced ~~by Apr 23~~ by June 2023 • EDS2 published Mar 23 with action plan to be delivered throughout the year and longer term • Gender pay gap actions embedded in organisation (between 2023-25) • Wider delivery of programmes such as cultural intelligence and civility matters across the whole organisation

Current Performance - Highlights

The following key performance indicators are highlighted from Integrated Performance Report:

- Updated 2022 staff survey results are being issued with local cascade and progression of actions and renewed focus
- A suite of leadership and cultured development work is underway for use in the short and medium term
- ~~Staff team talks have launched linked to staff survey results and actions collated in early June for monitoring progress later in the Autumn~~
- ~~The increase in time to resolve disciplinaries is in part due to availability of investigation officers time and resource c~~ Time to resolve disciplinary cases has improved and is being sustained to improve employee relations ~~apacity in the system~~
- More work is underway to seek to resolve grievances informally and encourage early resolution. ~~The time to resolve grievances continues to improve as a direct result of the ERAS team continuing to follow up and encourage early resolution~~

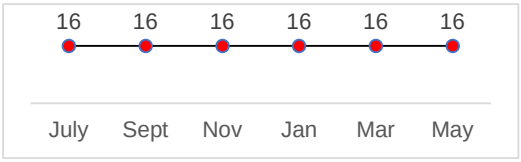
Associated Risks on the Board Risk Register

Risk no.	Description	Current score
6092	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered or enabled, impacting on the Trust's ability to deliver the required improvements and transformation, and impacting on the delivery of quality and compassionate care to the community.	16

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		**Risk score 16**
Strategic Risk No.7: **Immature place and system collaborative processes and culture**		
If the emerging ICS and place-based models do not develop at pace and we are unable to develop mutually collaborative approaches with partners throughout the system	***Then*** collaboration will stall, and partners will not trust us and vice versa	***Resulting in*** not delivering improved ways of working, missing the opportunities to improve health services and patient outcomes system-working offers; regulatory accountability and not achieving the system financial envelope.

	Impact	Likelihood	Score
Inherent	4	4	16
Current	**4**	**4**	**16**
Target	4	3	12

Risk Trend



Risk Lead	Deputy Chief Executive	Assurance committee	FPPC

Controls	Assurances reported **to Board and committees**
Strategies and Plans • Clinical Strategy and Trust objectives • Joint strategic needs assessment • ICB and HCP strategies and priorities **Financial Controls** • Cross System pathway transformation commissioning priorities at PLACE/ICB/ICS **Governance & Performance Management Structures** • ICB Board • ICS Board • Place Board • Scrutiny committee • Health and wellbeing board • ENH Tactical Commissioning Group **Relationships** • Strong networks around specific subject areas eg. UEC, Cancer etc	**First and second line (internal) assurances** • Escalation reports to: Quality and Safety Committee; People Committee: Clinical Audit & Effectiveness sub-committee • Integrated performance reports to Board/ Committees • Well led framework assessment and review reports • Elective recovery programme escalation reports • Feedback from ICB CEO attending Board bi-annually **Third line (external) assurances** • NHSE Board feedback forums
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Defined governance frameworks	• ICB/ICS/Place leadership group reports. Material to be shared via Diligent • Key ICS risks relevant to ENHT are seen by the Board (Stuart Dalton Apr 24) • System reports to the Board (MA/SD Nov 23)
• Missed opportunities to influence joint strategic needs assessment	• Influencing policy design at ICB and HCP level. Trust to determine strategy and mechanisms for influencing • A structured comms and engagement approach to formally sharing information, current challenges and successes with both the ICS, and partners within it- both on an ad hoc basis, but also within comms leads meetings (Eilidh Murray Sept 23)

	• Seek agreement from partner Chairs that Company Secretaries agree a list of supporting strategies and other key board documents that will be shared and how these will be shared (Stuart Dalton Sept 23)
• Developing role, responsibilities, and relationships	• Participation in System and Place development groups • NED collaborative working: Trial groups of NEDs from respective partners around their key responsibilities eg Chair for audit, FPPC, quality and People Cttee, maternity and wellbeing champions etc. Trial to see if these add value. (MA Apr 24) • Explore shared back office functions across the ICS (MA Dec 24)
• Developing cross systems relationships with agreed values and behaviours	• Participation in System and Place development groups • Externally facilitated Board development session on involvement within the system, how best to collaborate and work in partnership (use of case studies) (LM Dec 23) • Clearly log and publicise what we do to help to counteract negative narrative. (MA/EM Mar 24) • Invite ICS and HCP to Board (SD Mar 24)
• The trust should engage with the ICS to ensure that its strategy is aligned with the ICS strategy as that is developed.	• Seek views from the ICS on how best the Trust aligns our strategy with the ICS's (Circulation of summarised Trust Strategy document to stakeholders. Subsequent engagement sessions agreed and iteration where required) (LM Nov 23) • The Trust strategy to cover how it delivers the ICS strategy (iterate the Trust strategy chapters where appropriate) (LM Sept 23) • For ICS strategy and its BAF to be reviewed periodically by the Board) (SD Apr 24)

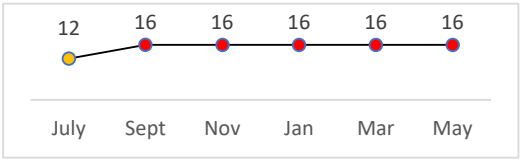
Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • the IPR does not include any measures that specifically highlight the effectiveness or not of collaborative arrangements

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		Risk score 16
Strategic Risk No.8: **Performance and flow**		
If we do not achieve the improvements in flow within the Trust and wider system	***Then*** the Trust's key performance targets will not be met	***Resulting in*** increased avoidable Serious Incidents, wider health improvements not being delivered and regulatory censure

	Impact	Likelihood	Score
Inherent	4	4	16
Current	4	4	16
Target	4	2	8

Risk Trend



Risk Lead	Chief Operating Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Recovery plans (Elective, cancer, stroke~~)~~), refreshed for 23/24 • Cancer Strategy and Cancer recovery plan, refreshed for 23/24 • Stroke recovery plan • System UEC strategy (incl ambulance and discharge flow) • UEC rapid action event (Sept 22), with resulting action plan monitored weekly by Execs • UEC Transformation Programme (including ambulance handovers~~)~~), refreshed for 23/24 • Support from ECIST (Emergency Care Improvement Support Team) – improvement actions and plan agreed • Tailored support requested by ENHT and agreed from national & regional UEC teams and ECIST (April 23) • ENHT will participate in EoE ED Peer Review (Dr Leilah Dare) • New leadership from 17 April – Trust Director of Operations & Performance **Performance Information Controls** • IPR • Deep dives • Qlikview dashboards – used to provide immediate access to data across a number of domains to enable effective management of performance **Governance & Performance Management Structures** • Operational restructure underway to further develop clinical and operational leadership, clear accountabilities, shared learning, QI approach • Transformation programmes at the Exec Programme Board • ARMs – includes exception reports • Divisional Board meetings • Regular tumour group meetings and improvement workstreams • System-wide Cancer Board chaired by Lead Divisional Director for Cancer • Specialty exception meetings	**First and second line (internal) assurances** • Board (IPR; transformation reports) • FPPC (IPR & deep dives) • Board Seminars (e.g. elective recovery Feb 22) **Third line (external) assurances** • Quality & Performance Review Meeting (chaired by ICS with CQC) • Herts & West Essex ICS UEC Board • ENH performance meeting (chaired by ICS Director of Performance) • National Tiering system

Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
• New NHSE performance metrics (62 days cancer and ~~78~~65 weeks waits)	• ARM meetings – a revised format is currently being developed. – Completed • Demand and Capacity undertaken at speciality level and plans developed for 65 week wait by March 2024. Trajectory to compliance for all specialities except Community Paediatrics - complete • ICB system work to address Community Paeds demand/ capacity mismatch – ongoing
• Scope of validation of Patient Tracking Lists	• Increasing validation of Patient Tracking Lists – by Quarter 4 22/23 – completed
• Ambulance intelligent conveyancing lack of proactiveness	• System solution to intelligent conveyancing/ambulance intelligence will improve, but not fully address the challenge - ongoing
• Lack of social care and community capacity to support discharge • Utilisation of Hospital at Home not yet optimal – further work being undertaken to increase uptake.	• Extending scope of hospital at home – not matching what we need (taking patients who are awaiting packages of care). This will partially address the challenge of timely discharge for medically optimised patients. – ongoing [timeline to be confirmed once known] • E referral to be introduced for Hospital @ Home
• Capacity to increase referrals to cancer pathways	• Review of ARM meetings to ensure effectiveness – by Quarter 4 –Completed
• Clinical and administrative processes for progressing patients through their pathways	• System being implemented to speed up the process of informing patients they do not have cancer – Quarter 4 22/23 - Completed
• Diagnostic wait times – Access Board, Cancer Board	• Demand and capacity analysis – Quarter 3 22/23 – Completed – presented to Jan 23 FPPC • Additional capacity in plan: CT, echo, ultrasound, DEXA, MRI and plain film – Quarter 4 22/23 – completed
• Consultant Vacancy rates in some services (Anaesthetics, Orthopaedics)	• Recruitment plans ~~forming~~are part of Divisional operating plans
• Willingness of consultants to undertake extra contractual sessions	• New rates agreed Feb 23. Further limited incentive agreed March 23, with agreement of anaesthetists to recommence extra contractual sessions from April 2023

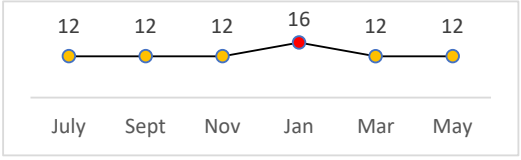
Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • % of 62 day PTL over 62 days • 62-day/ 31-day cancer performance • 78 weeks RTT • Ambulance handovers • ED 4 and 12 hour performance • Diagnostic waits • 2 week waits • Stroke performance

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		**Risk score 12**
Strategic Risk No.9: Trust and system **financial flows and efficiency**		
If finances do not move around the system in recognition of costs incurred in new models of care	***Then*** our and our partner financial positions will deteriorate	***Resulting*** in the inability to fund planned service delivery and regulatory scrutiny

	Impact	Likelihood	Score
Inherent	4	4	16
Current	4	3	12
Target	3	3	9

Risk Trend



Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Signed SLA contracts with ICS commissioners for 22/23 – embedding finance and associated plans. • Clinical Strategy and associated prioritisation and development framework. Linked to place priorities. **Financial Controls** • Monthly ERF & SLA activity reporting schedules **Governance & Performance Management Structures** • Establishment of SFA team to provide strategic finance transformation evaluation support • Bi-weekly ICS System Leaders meeting • Bi-weekly ICS DoFs and DDOFs meeting • Monthly E&N Herts Partnership Board & associated meetings • Elective Surgical Hub, Community Diagnostic Hub, Virtual Hospital and Heart Failure local and regional governance arrangements • PHM reporting mechanism to track changes in patient flows and associated costs and income • PHM steering and development group and link to place and system PHM development activity	**First and second line (internal) assurances** • System and Provider Collaboration reports to Trust Board advising on activity • Monthly project review sessions between Finance & Transformation Team. Transformation activity updates included in FPPC business cycle **Third line (external) assurances** • Consolidated ICS financial performance reports • Share further ICS performance reports as circulated by ICS.

Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
• Risk of non-payment of ERF overperformance by ICB and NHSE	• Outturn ERF positions with both HWE ICS and Specialist Commissioning agreed for 22/23.
• Establishment of transparent financial reporting environment across ICS partners	• Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation
• Development of ICS financial risk management strategy	• Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation
• Determination of place based financial responsibilities	• Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation
• Development of long-term financial plan for ICS	• Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation

• Acute Provider Collaborative and associated business rules	• Approved by Trust CEOs – Sep 22. CEOs to review and approve collaborative governance arrangements. Move to implementation phase
• Further Board dialogue to be facilitated to help develop further metrics that can support assurance	• To be addressed through future board development sessions

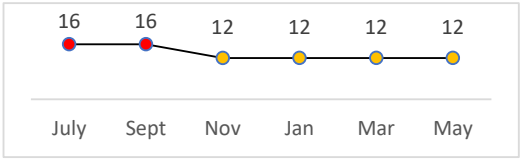
Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • Performance against ERF income and activity targets • Delivery of CDC activity levels

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**		Risk score 12
Strategic Risk No.10: **Technology, systems and processes to support change**		
If staff do not have the technology, systems and processes in place to support change and staff do not engage with or understand new continuous improvement processes and methodologies	***Then*** the pace of transformation delivery will falter	***Resulting in*** failing to improve productivity, deliver efficiencies and performance targets and ultimately the Trust being unable to deliver our strategic ambitions to timescale

	Impact	Likelihood	Score
Inherent	4	4	16
Current	3	4	12
Target	2	3	6

Risk Trend



Risk Lead	Director of Transformation	Assurance committee	QSC

Controls	Assurances reported to Board and committees
Strategies and Plans • Board approved 22/23 Strategic Objectives • 10 Year Integrated Business Plan • Digital Roadmap • Front Line Digitisation **Systems and Resources** • QlikVIew dashboards/ deployment of SPC methodology **Governance & Performance Management Structures** • Executive Programme Board • Clinical Digital Design Authority • GIRFT Board • Programme and project delivery framework • ENH HCP Transformation Delivery Group • Provider collaborative Programme Board **Quality Management Processes** • Here to improve model **Training and Sharing Best Practice** • Trust-wide training and development programme • Learning events, safety huddles and debriefs	**First and second line (internal) assurances** • Monthly Divisional Board and Transformation meetings • Monthly programme reports • Digital programme boards • Key performance metric reporting to Board/Committees • Board and Committee transformation update reports • External /internal audit review of key programmes i.e., transformation portfolio, efficiency and productivity, strategic projects **Third line (external) assurances** • Annual and Pulse staff surveys • National benchmarking reports • NHS Model Hospital Portal • GIRFT programme

Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
Control gaps • Single improvement methodology not established across the organisation	**Control treatments** • Procurement process to identify an improvement partner to roll-out a Quality Management System to commence December 22/23.
• Consistency with engagement across all staff groups to support improvement projects	• Roll-out strategic objectives aligned with Grow Together conversations and new Trust values and behaviors
• Ongoing number of trust projects require cultural change and formal organisational redesign approaches	• Formalisation of an organisational development change model & engagement programme to commence Dec 22/23 as part of Quality Management System preparation.
• Variation in business-as-usual systems and processes	• Adoption of lean thinking in pathway redesign model as part of the new Quality Management System.

• Improvement training compliance is variable across staff groups and levels of seniority	• Review of the current dosing model for improvement skills and training following confirmation of Improvement Partner in Q1 23/24.
• Benchmarking data comparisons not routinely understood to inform improvement priorities	• Development of a new annual benchmarking programme to monitor and evaluate performance and priorities to commence Q4 22/23.
Assurance gaps • Performance data indicates issues with sustaining changes & embedding culture of improvement & learning	**Assurance treatments** • Review of current processes for aggregated Trust learning and gap analysis plan to be developed by end Q4 22/23.
• Programme milestones and KPIs reflect compliance issues with Trust project management principles	• New strategic project management governance framework established. Ext audit scheduled Q4 22/23.
• Engagement in the design and adoption of digital systems	• Review of mechanisms to ensure stakeholders have adequate time to engage in design and transformation. • Executive Programme Board to provide oversight and leadership regarding alignment resourcing and decisions
• Alignment of new transformation portfolio digital requirements with overarching Digital Roadmap	• Executive Programme Board to provide oversight and leadership regarding alignment resourcing and decisions

Current Performance - Highlights

- ~~ITT procurement exercise for Improvement Partnership concluded 17th March with top two suppliers invited to an on-site presentation on 5th April.~~
- ~~New 'Gemba' style approach established by transformation team to support the new Endoscopy improvement programme as a precursor to expected Improvement Partner changes.~~
- ~~Managing Organisational Change toolkit already developed and revised Managing Organisational Change Trust policy approved with staff side.~~
- ~~Benchmarking review for Theatres and Outpatients using NHS Model Hospital Portal, GIRFT and other datasets incorporated during Q4 into a series of specialty 'Heatmap's' to identify areas of opportunity for 23/24 portfolio development.~~
- ~~Improvement in learning processes across the organisation has involved the a)development of the new national Patient Safety Incident Response framework b) establishment of learning capture behind every complaint response letter and commencement of complainant satisfaction questionnaires c) a new robust learning evaluation for all EPB strategic programmes, and d) a new place based Learning Network led by ENHT with a series of learning events between ENHT and PAH already occurring throughout the year.~~
- ~~Three TIAA audits now complete covering main strategic objective portfolio with two assessed as substantial, and one as reasonable assurance. All management actions complete or on track.~~
- ITT procurement presentations for top 2 IP suppliers occurred April 5th; award letters to be sent w/c April 10th before the 10 day stand still. Expectation remains for soft landing of successful IP in June.
- Updated Bronze Project Management training programme launched in March 22/23.
- A end-of -year stock take and learning exercise involving the strategic objectives portfolio reported to EPB in March.

Associated Risks on the Board Risk Register

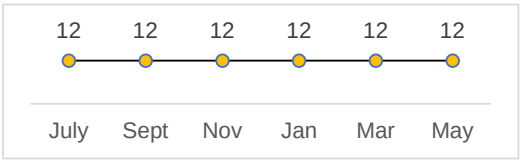
Risk no.	Description	Current score
6092	There is a risk our staff do not feel fully engaged which prevents the organisation maximising efforts to deliver quality care.	16

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**	Risk score 12
Strategic Risk No.11: **Enabling innovation**	

If we do not foster a learning culture where experimentation and questions are encouraged and staff are supported to innovate and do the right thing when mistakes happen	***Then*** there is the risk staff will become disempowered, will not identify solutions, not challenge without fear, not learn from mistakes and managers will hide issues and the culture will be psychologically unsafe.	***Resulting in*** avoidable harm to patients, missed opportunities for improvement and potential regulatory intervention and a culture of uncivil behaviour and lack of trust amongst staff

	Impact	Likelihood	Score
Inherent	5	4	20
Current	4	3	12
Target	3	3	9

Risk Trend



Risk Lead	Director of Transformation	Assurance committee	People

Controls	Assurances reported to Board and committees
Strategies and Plans • Quality / Patient Safety Strategy • EDI strategy **Systems and Resources** • QlikView Quality dashboards • Quality Oversight System 'EnHance' • Change Toolkit and Policy **Governance and Performance Management Structures** • Patient Safety Forum(s) • Collaborative(s) (harm free care/ deteriorating patient) • A just culture guide for evaluating patient safety incidents • Freedom to speak up guardian / network • Mortality review process • Clinical audit programme **Learning from Incidents** • Clinical and serious incident review panels • Schwartz rounds/ quality huddles/ Here for You sessions • After Action Review debriefs **Quality Management Processes** • CQC and compliance preparedness framework • Incident management KPIs • Patient safety specialist role (s) **Training and sharing best practice** • RCN Clinical Leadership Programme • QI Bite size, masterclass & coaching sessions • PDSA / quality improvement in action • Leadership rhythm / bite-size sessions • Human factors simulation training	**First and second line (internal) assurances** • Divisional quality meetings/ structures • Accountability Review Meetings • Key performance metric reporting to Board/Committees • External/ internal audit review programme i.e., BAF & Risk Management, MHPS • CQC peer/ ICB review assessments • Risk Management Group **Third line (external) assurances** • Annual and Pulse staff survey results • Care Quality Commission assessment process • ICB / Place Quality Surveillance Group • NHS patient survey results • NHS clinical incident reporting benchmarking
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Control gaps • Single improvement methodology not established across the organisation	**Control treatments** Develop and roll-out a Quality Management System with Improvement Partnership support due to commence in Quarter 2 23/24.

• Freedom to Speak up Strategy not launched or imbedded	• Develop leadership and management framework to support freedom to speak up processes as part of BAU in Q4 22/23 Update: Freedom to Speak Up Strategy in draft format and under consultation with stakeholders with planned submission by FTSU Guardian for Committee sign-off now scheduled for early Q1 23/24.
• Variation in ward to Board quality governance structures and operational procedures	• Good Governance Institute review. • National Safety Incident Framework launch in Q1 23/24 in a phased approach.
Assurance gaps • Efficacy of current learning systems from incidents, complaints, audit and wider performance issues where there are reoccurrences of similar themes and outcomes.	**Assurance treatments** • Review of systems to capture and share learning • Develop and launch a refreshed vision for learning and improvement, closely linked to strategic objectives and Trust values to commence Q3 22/23. Update: Review and improvement in learning processes across the organisation has involved the a) development of the new national Patient Safety Incident Response framework b) establishment of learning capture behind every complaint response letter and commencement of complainant satisfaction questionnaires c) a new robust learning evaluation for all EPB strategic programmes, and d) a new place-based Learning Network led by ENHT with a series of learning events between ENHT and PAH already occurring throughout the year.
• Level of staff absence, survey feedback themes and grievances reported by staff through FTSU Guardian.	• Review of ward/specialty MDT governance processes - develop MDT ward leadership model • Development of ICB / Place learning network Update: Specialty and Ward MDT leadership model and structure to be incorporated into the next Divisional redesign phase, scheduled for consultation in Q1 23/24.

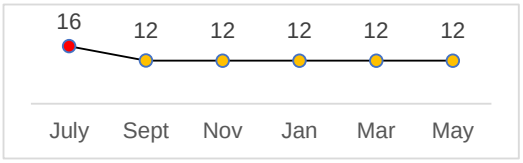
Current Performance - Highlights
• ~~Selection Questionnaire process for the Improvement Partner procurement completed 20th January with five suppliers shortlisted for final stage.~~ • ~~Action plan incorporating QI capability building as part of recommendations from the Good Governance Institute report completed.~~ • ~~Overview of new PSIF framework and internal roll-out plan submitted by Director of Quality and approved at TMG 5th January.~~ • ~~New complaints process underway with learning capture a standard requirement of the new triage documentation.~~ • ITT procurement exercise for Improvement Partnership concluded 17th March with top two suppliers invited to an on-site presentation 5th April. Tender specification conforms soft landing during Q2 before wider launch in Q3 23/24. • Learning sessions also now established as routine following all major operational and/or emergency planning incidents with most recent example covering junior doctor industrial action. • Place-based learning network now established with wider ICB learning events underway involving ENHT and PAH; discussions for an ICB-wide learning network are ongoing.

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
6092	There is a risk our staff do not feel fully engaged which prevents the organisation maximising efforts to deliver quality care.	16

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**			Risk score 12
Strategic Risk No.12: **Clinical engagement with change**			
If the conditions for clinical engagement with change and best practice are not created and fostered	***Then*** we will be unable to make the transformation changes needed at the pace needed	***Resulting in*** not delivering our recovery targets or improved clinical outcomes; not building a financially sustainable business model; and being unable to contribute fully to system-wide improvements	

	Impact	Likelihood	Score
Inherent	4	4	16
Current	4	3	12
Target	4	2	8

Risk Trend



Risk Lead	Medical Director; (Chief Nurse)	Assurance committee	QSC

Controls	Assurances reported to Board and committees
Strategies and Plans • Clinical Strategy • Quality Strategy **Information systems and resources** • QlikView Quality dashboards • Life QI • Datix / 'ENHance' • GIRFT • KOPs programme **Governance and Performance Management Structures** • Operational committees e.g. Patient Safety Forum, Mortality surveillance committee **Learning from Incidents** Key performance SOPs e.g. Incident learning responses: serious incident reports, round tables, restorative culture framework – new Patient Safety Incident Response Framework (PSIRF) to be introduced to respond to patient safety incidents to learn and improve patient safety **Quality Management Processes** • CQC and compliance preparedness framework • Safety Incident management framework • Quality Improvement service • Transformation service • Reward and recognition **Training and sharing best practice** • Royal College of Nursing Clinical Leadership Programme • Clinical Directors development Programme • Clinical Directors' Away Days • New Consultants development programme • Improvement and transformation capability sessions • Quality Improvement coaching • Leadership and human factors development programmes • Research programmes **Staff engagement and well being** • Here for you health at Work	**Internal Committee-level assurances** **Sub Board Committees** • Quality and safety Committee report • Education committee escalation report • Clinical Audit and Effectiveness Committee escalation report Safety Culture survey **Third line (external) assurances** • Annual and Pulse staff survey results • Care Quality Commission assessment process • ICB / Place Quality Surveillance Group escalation report • NHS patient survey results • Peer assessment review report and action plan • External/ internal audit programme reports and action trackers • Getting it Right First Time national programme • GMC Survey

• Values and behaviour programmes • Freedom to speak up guardian / network • Medical Director quarterly update presentations & Q&A session - All consultant & SAS doctors invited • Medical Director's quarterly newsletter • MAC, LNC & JDF • Trainees in Leadership Support Group • Healthy teams Programme • Kindness and Civility Programme	
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
Control gaps Skills and knowledge within clinical workforce to learn how to drive change	• Combined efforts to drive skills and knowledge by people team, transformation team, quality improvement team and business information's analysts in progress • Engage with an improvement partner *end of Q3 2023/24 – likely to be in place earlier*
Capacity within clinical roles to apply change methodology	• Agreed job planning and rostered time demonstrated through Roster on PA allocation. To be reviewed as part of job planning criteria for 2023, full rollout by Q4 23-24 • Proposal to provide selection of trainees time to be involved in KOPs/QI and transformational projects
Unwarranted variation in quality assurance framework	Redesign quality assurance framework *by end of Q3 22/23* [OVERDUE]
Current national safety Incident framework	New safety incident response framework implements *by end of Q4 23-24*
No allocated Medical lead Quality Improvement	In short term lead identified is Associate Medical Director for Quality and Safety. Appointment of Deputy Medical Director for Quality Improvement scheduled for Q1, 2023-4
Operational pressures, especially throughout Q3 and Q4	Risk based approach to quality improvement and prioritising
Assurance gaps Improving evidence of imbedded sustainable changes following learning from incidents, complaints, audit, and wider performance issues	New national safety incident response framework (PSIRF) to be implement by Q4 23-24 will improve evidence

Current Performance - Highlights
The following are highlighted from the most recent Integrated Performance Report: • Sustained improvement in recognition and management of sepsis • Sustained improvement in incident reporting • Sustained improvements in learning form deaths and mortality outcomes

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	10
Report title	Strategic Objectives 2023/24			**Meeting Date**	3 May 2023
Presenter	Adam Sewell-Jones, Chief Executive				
Author	Adam Sewell-Jones, Chief Executive				
Responsible Director	Adam Sewell-Jones, Chief Executive			**Approval Date**	23 April 2023
Purpose (*tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Report Summary:

This report proposes to the Board the strategic objectives for adoption covering 2023/24.

In 2022/23 the Board agreed its refreshed vision and four strategic themes to move the organisation towards the vision. Two strategic objectives were identified against each theme for particular focus during the year and progress against these has been regularly reported to the Board by the Director of Improvement.

This report contains the objectives proposed by the executive team for adoption by the Board.

The objectives are not intended to be all encompassing but rather areas of focus to make considerable progress towards the Trust vision.

The objectives will help shape the personal objectives of the chief executive and executive directors and the process is cascaded through the organisation with divisions and departments setting local strategics priorities, again influenced by the Trust level ones.

Impact: where significant implication(s) need highlighting
Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

This process will affect each of the CQC domains

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

These objectives once achieved should contribute to mitigating each of the BAF risks

Report previously considered by & date(s):

Trust Management Group

Recommendation	The Board is asked to approve the strategic objectives for 2023/24

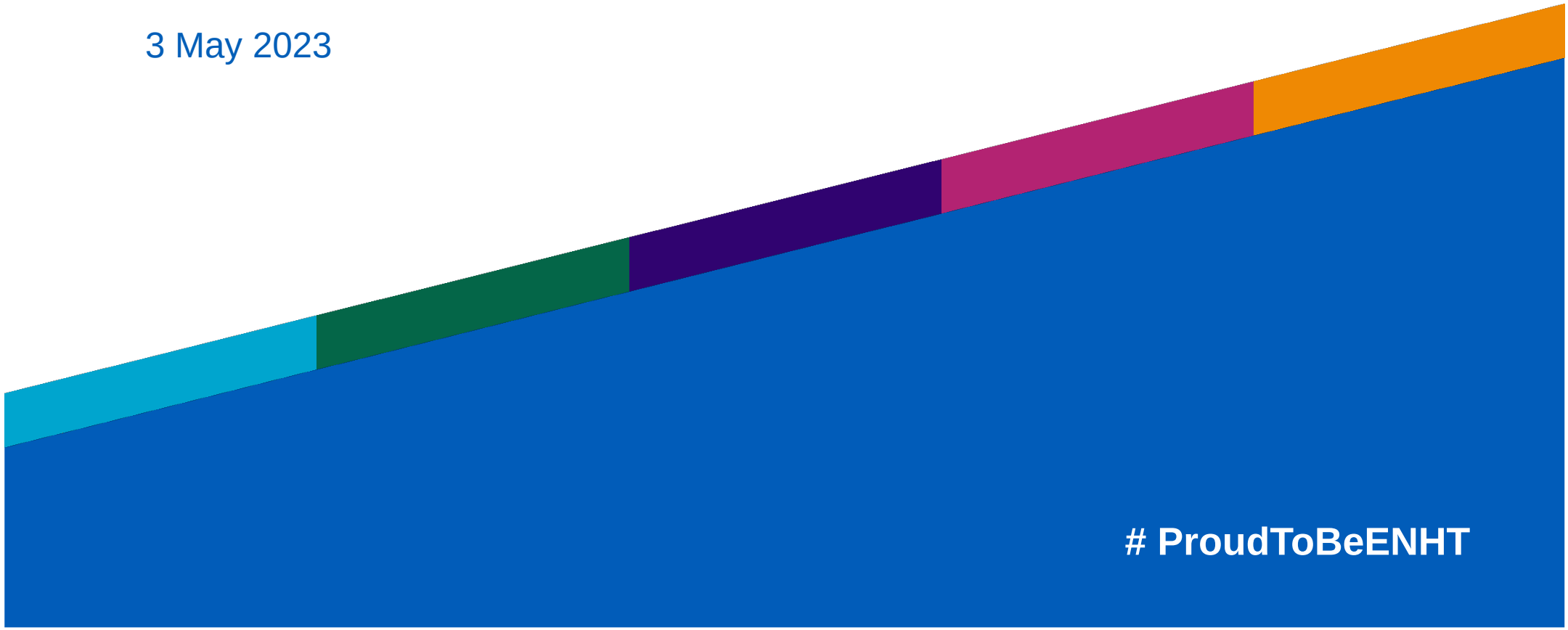
To be trusted to provide consistently outstanding care and exemplary service

Strategic Objectives 2023/24

Adam Sewell-Jones, Chief Executive

3 May 2023

East and North Hertfordshire NHS Trust



NHS East and North Hertfordshire NHS Trust

Our Trust mission

Providing high-quality, compassionate care for our communities

Our guiding themes

Quality
Consistently deliver quality standards, targeting health inequalities and involving patients in their care.

Thriving people
Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability.

Seamless services
Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners.

Continuous improvement
Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities.

Objectives 2023-24

- Embed fundamentals or care/pathways to excellence programme within all inpatient areas across the Trust
- Improve overall Trust regulatory compliance and deliver Maternity Improvement plan to meet requirements of CQC, Ockendon review and NHS Resolutions
- Improve our overall recruitment and retention rates to ensure that temporary workforce make up no more than 8% of the pay bill
- Ensure all staff have a quality Grow Together conversation and are fully compliant with statutory and mandatory training
- Transform end-to-end discharge pathways supported by a new urgent and emergency care model to deliver the A&E four-hour standard of at least 76% by March 2024
- Deliver Care Closer to Home pilots at individual GP Surgery and East and North Hertfordshire level targeting better meeting the needs of the highest intensity users of health services
- Implement a Quality Management System supported by an expert strategic partner with first quality and financial improvements delivered by March 2024
- Increase elective activity through productivity and investment, supported by a more digitally-enabled central booking service

Vision to 2030

To be trusted to provide consistently outstanding care and exemplary service

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	11
Report title	East and North Hertfordshire NHS Trust 2022 National Staff Survey Results			**Meeting Date**	3 May 2023
Presenter	Thomas Pounds, Chief People Officer				
Author	Thomas Pounds Chief People Officer, Amanda Harcus Deputy CPO				
Responsible Director	Thomas Pounds, Chief People Officer			**Approval Date**	12 April 2023
Purpose (*tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

This report provides a summary and key findings from the national staff survey in 2022.

- Engagement was significantly improved compared to previous years with a 47% compared to a national average of 44%. Response proportionately represented the diversity of the Trust.
- Results for each theme were broadly in line with benchmark group with the exception of 'we are always learning which was 0.3 points below average. Under the sub-themes the key driver was the response to the question on appraisal which reflected the low uptake at the time.
- The Trust has fallen further behind the benchmark average in total with 6 themes being marginally below average compared to only 2 the previous year.
- The Trust had a significant positive swing in the reporting of violence and bullying and harassment
- Nursing and Midwifery and Admin were amongst the most positive staff group and Medical and Estates and ancillary were the least positive
- Many of the Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) indicators have mostly moved in a positive direction however it should be recognised that there remains a disparity in experiences.
- The cycle of engagement continues with team talks and further development values charter

Impact: where significant implication(s) need highlighting
Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

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

n/a	
Report previously considered by & date(s):	
n/a	
Recommendation	The Committee is asked to: • note the contents of the report

To be trusted to provide consistently outstanding care and exemplary service

East and North Hertfordshire NHS Trust 2022 National Staff Survey Results: Key Findings

Thomas Pounds

May 2023

2022 National NHS Staff Survey

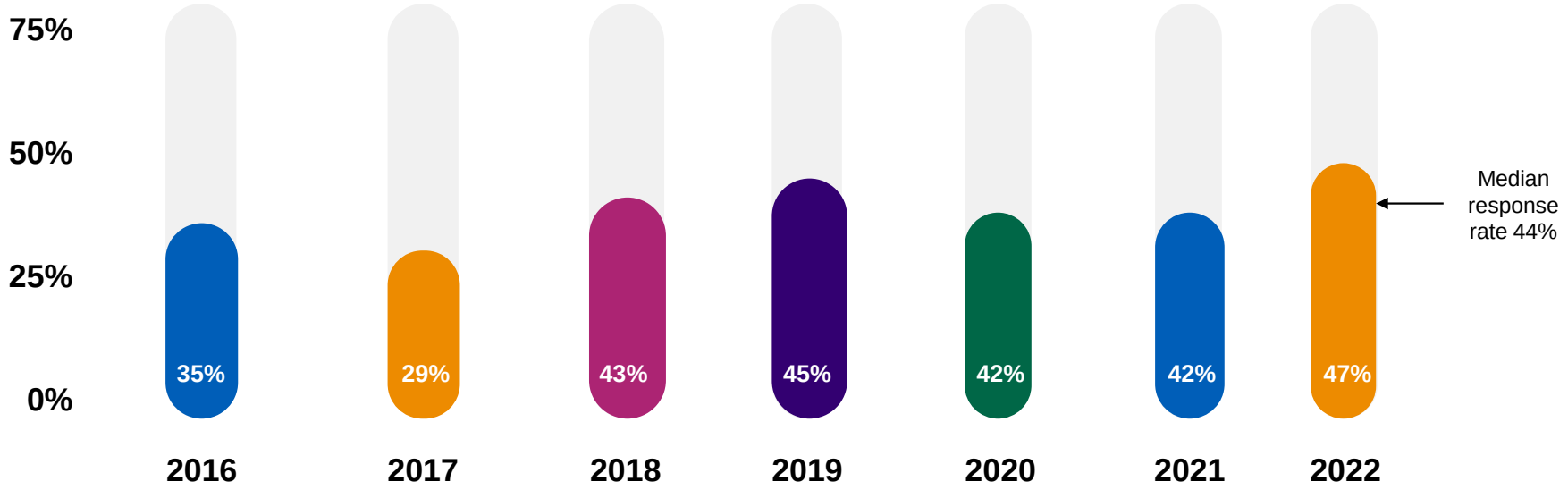
East and North Hertfordshire NHS Trust

- Used by the NHS and CQC to judge and assess Trust performance
- Links have been shown between staff engagement, patient experience and patient outcomes
- The survey has been refreshed to align with the 7 People Promise elements. Two previous themes, Staff Engagement and Morale, remain
- The Trust's fieldwork period started 19th September 2022 and closed 28th November 2022
- The National results were released on Wednesday 9th March 2023

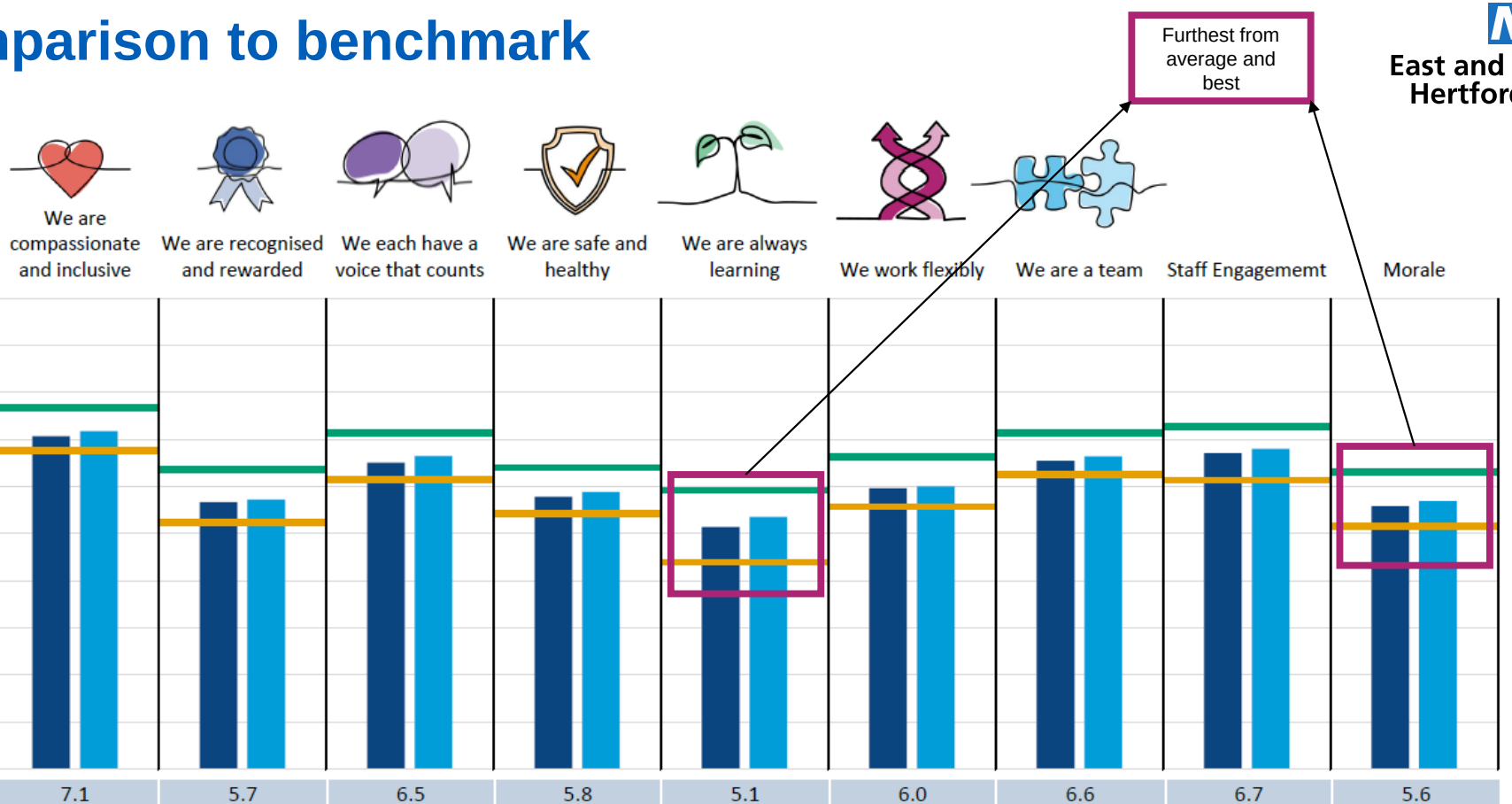
Engagement Rate

East and North Hertfordshire NHS Trust

- All staff census completed and returns were electronic only
- 2963 (47%) staff completed the return – median response rate was 44%
- The proportion of respondents by protected characteristic was representative of the entire Trust



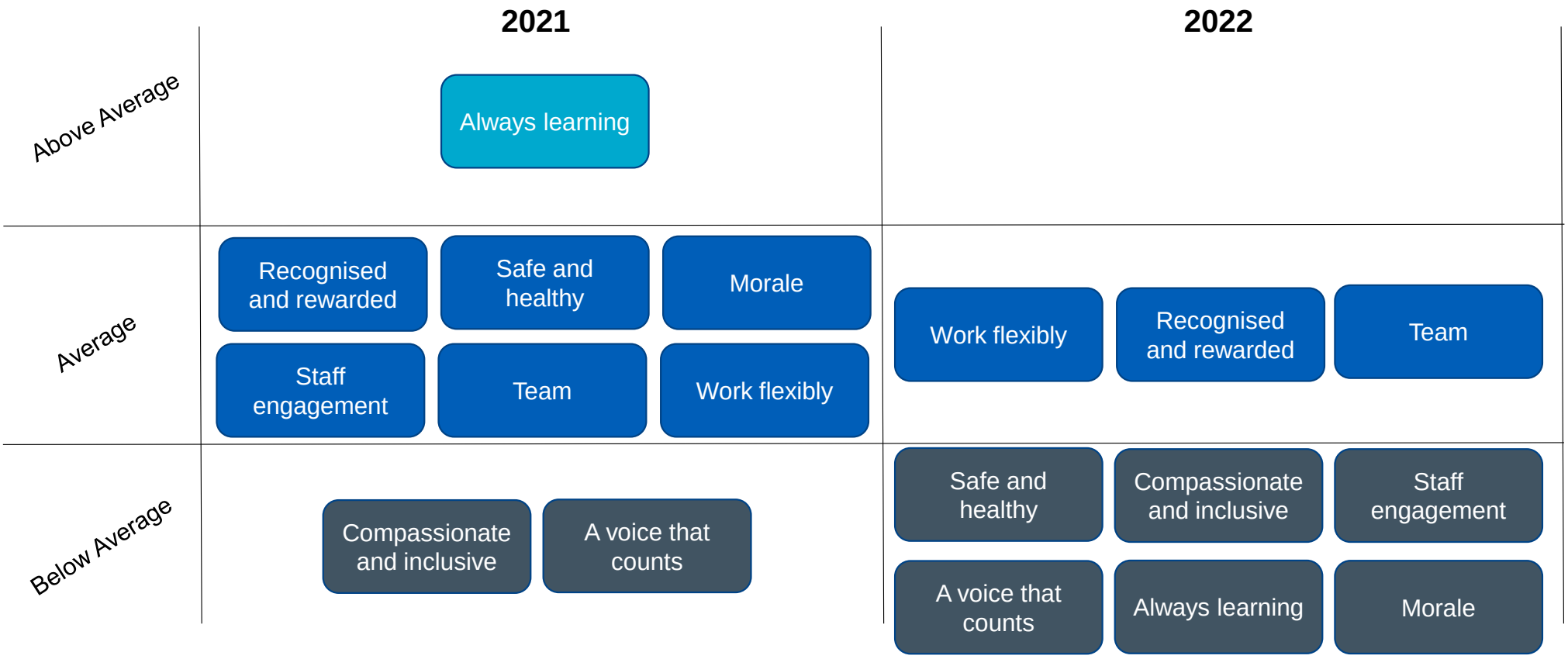
Comparison to benchmark



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.1	5.7	6.5	5.8	5.1	6.0	6.6	6.7	5.6
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	2951	2950	2923	2941	2796	2940	2945	2955	2956

Benchmark year on year comparison

East and North Hertfordshire NHS Trust

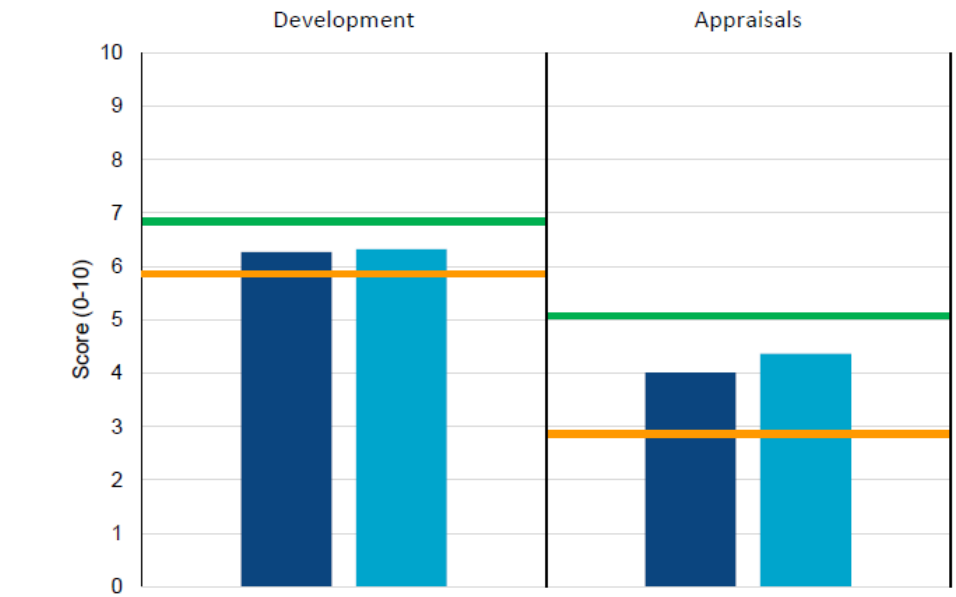


5 | National Staff Survey Results

Sub-themes – hot spots

East and North Hertfordshire NHS Trust

Promise element 5: We are always learning



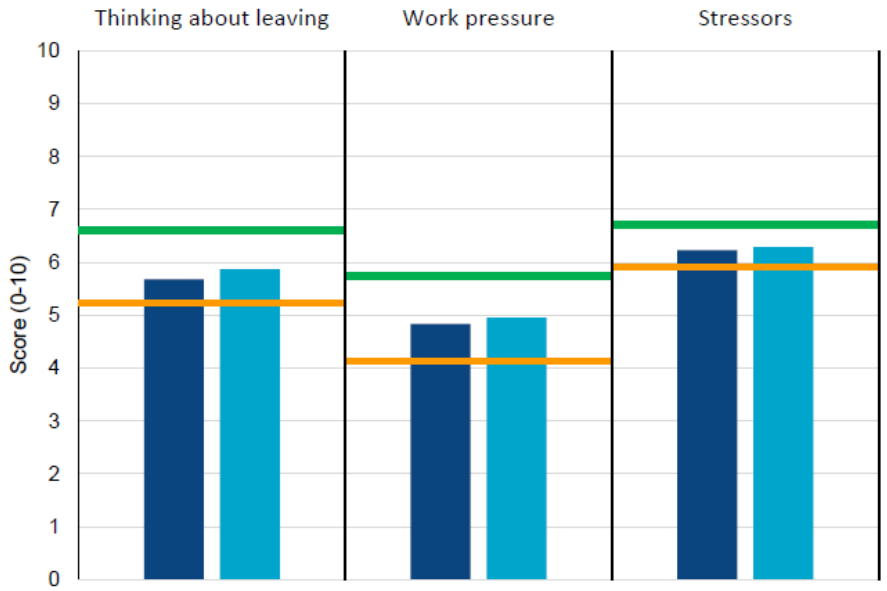
	Development	Appraisals
Your org	6.3	4.0
Best	6.8	5.1
Average	6.3	4.4
Worst	5.9	2.9
Responses	2940	2809

	2021	2022	dif.
In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review	77.01%	74.10%	-2.91%
It helped me agree clear objectives for my work	33.45%	35.11%	1.66%
It helped me to improve how I do my job	25.33%	26.38%	1.05%
It left me feeling that my work is valued by my organisation	31.50%	31.33%	-0.17%

Sub-themes – hot spots

East and North Hertfordshire NHS Trust

Theme: Morale



	Thinking about leaving	Work pressure	Stressors
Your org	5.7	4.8	6.2
Best	6.6	5.7	6.7
Average	5.9	5.0	6.3
Worst	5.2	4.1	5.9
Responses	2948	2949	2948

	2021	2022	dif.
My immediate manager encourages me at work	67.94%	66.82%	1.13%
I have a choice in deciding how to do my work	49.20%	50.75%	-1.55%
I often think about leaving this organisation	38.28%	40.58%	-2.30%
I am involved in deciding on changes introduced that affect my work area / team / department	48.08%	50.47%	-2.39%
I am able to meet all the conflicting demands on my time at work	43.13%	46.67%	-3.55%
I always know what my work responsibilities are	84.01%	87.57%	-3.55%
There are enough staff at this organisation for me to do my job properly	23.13%	26.95%	-3.82%

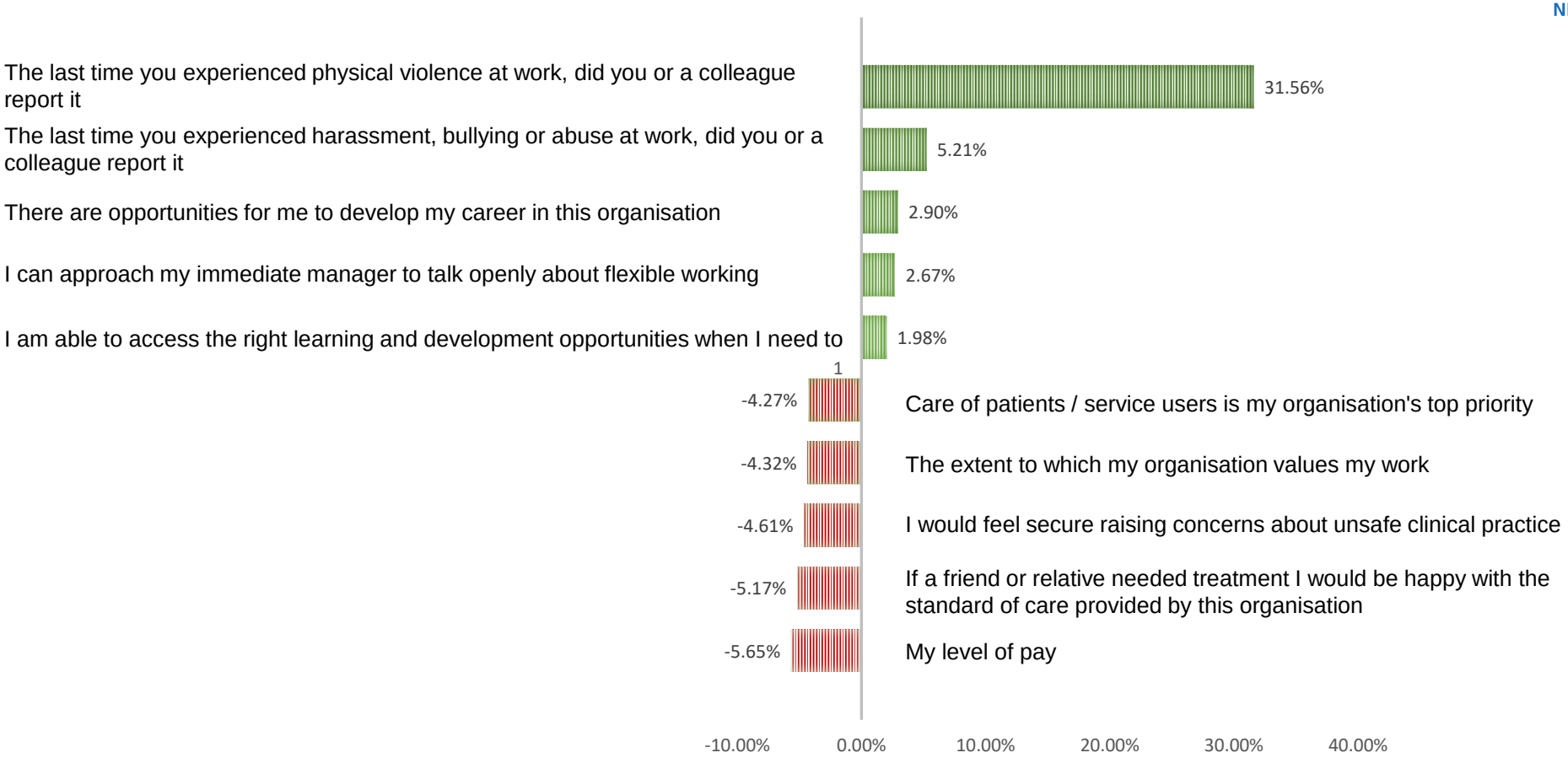
Comparison to last year

NHS
East and North Hertfordshire
NHS Trust

People Promise elements	2021 score	2021 respondents	2022 score	2022 respondents	Statistically significant change?
We are compassionate and inclusive	7.2	2639	7.1	2951	Significantly lower
We are recognised and rewarded	5.8	2639	5.7	2950	Significantly lower
We each have a voice that counts	6.6	2597	6.5	2923	Significantly lower
We are safe and healthy	5.9	2614	5.8	2941	Not significant
We are always learning	5.2	2489	5.1	2796	Not significant
We work flexibly	6.0	2628	6.0	2940	Not significant
We are a team	6.6	2634	6.6	2945	Not significant
Themes					
Staff Engagement	6.8	2640	6.7	2955	Significantly lower
Morale	5.7	2641	5.6	2956	Significantly lower

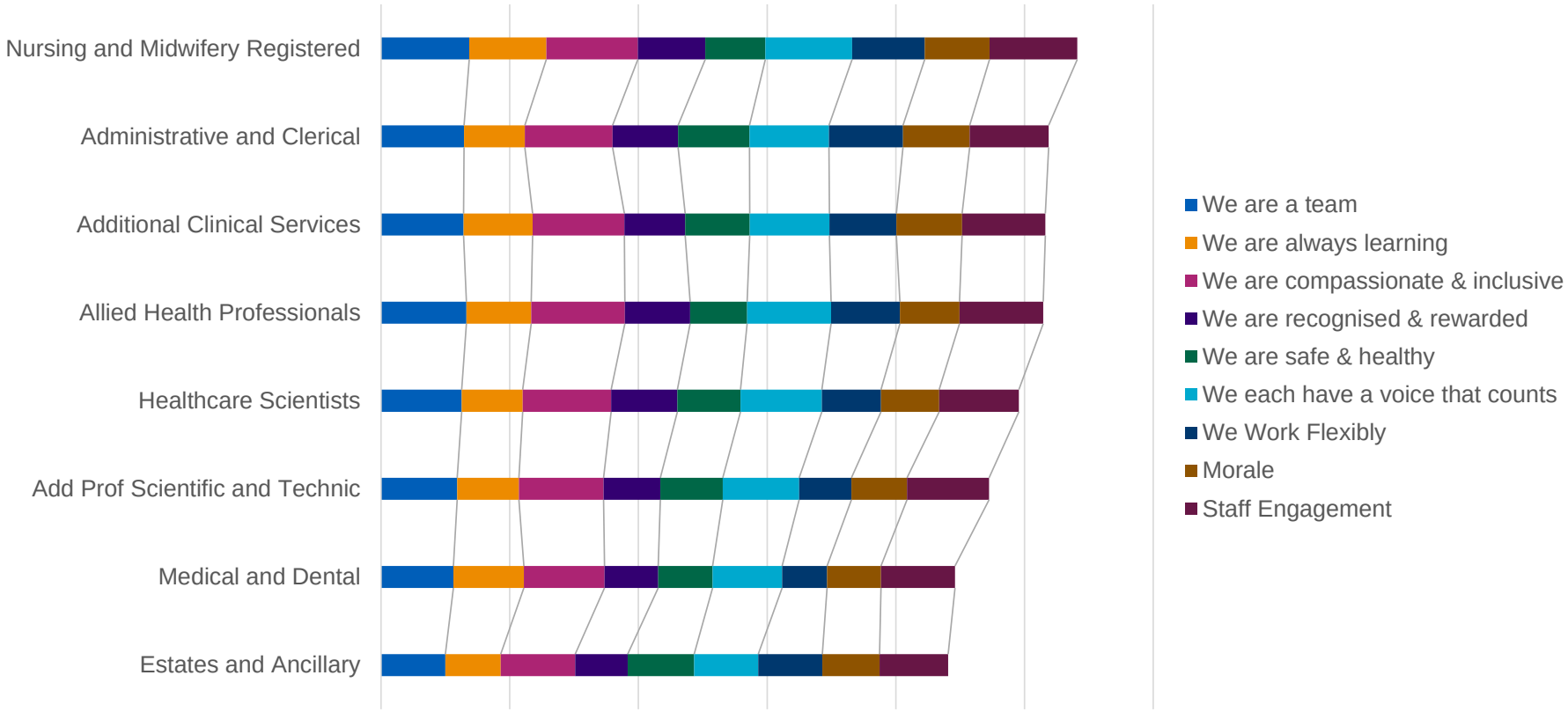
Largest swing (best and worst)

East and North Hertfordshire NHS Trust



Positive scores by staff group

East and North Hertfordshire NHS Trust



Performance by service

East and North Hertfordshire NHS Trust

WRES and WDES indicators

East and North Hertfordshire NHS Trust

WRES indicators

	White staff	All other ethnic groups	Dif.
Exp. HBA* patients, relative and public	32.2	32.2	0
Exp. HBA* from staff	26.5	30.8	4.3
Equal opportunities for career progression	54.7	50.2	4.5
Exp. Discrimination from manager/team leader/colleagues	8.9	15.8	6.9

*Harassment, bullying and abuse

WDES indicators

	Without LTC** or illness	With LTC** or illness	Dif.
Exp. HBA* patients, relative and public	30.4	39	8.6
Exp. HBA* from managers	12.3	22.3	10
Exp. HBA* from staff	20.5	32.6	12.1
Reporting of BHA*	47.1	49.7	2.6
Equal opportunities for career progression	54.3	46.7	7.6
Pressure from manager to come to work when not well	22.3	33.2	10.9

*Harassment, bullying and abuse

*Long term condition

Improved

No significant change

Worsened

Next steps for 2023/24

NHS East and North Hertfordshire NHS Trust

April

Q1 Pulse survey

July 2023

Q2 Pulse survey

October 2023

Q3 Pulse Survey

May 2023

Staff survey results cascade to divisions and actions reviewed

Actions linked to balance scorecard and integrated into divisional performance packs

June – August 2023

Action plans and updates shared with staff networks and support on progress provided

Engagement with staff stakeholder groups

Culture work continues

August – November 2023

Regular communication and engagement with staff locally on action progress and raising awareness through team talks of you said we did; team charters and staff survey actions

September - Staff survey 2023 opens

September – December 2023

Engagement continues

Action plans updated and reported on at people committee

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	12
Report title	Annual review of Standing Orders & Scheme of Reservation and Delegation			**Meeting Date**	3 May 2023
Presenter	Stuart Dalton, Head of Corporate Governance				
Author	Stuart Dalton, Head of Corporate Governance				
Responsible Director	Martin Armstrong, Deputy CEO			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Report Summary:

Updated Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions are enclosed for review and approval.

As part of the annual review of the Standing Orders (SOs) and Scheme of Reservation and Delegation (SoRD) it became clear that a limited number of reservations within the SoRD were at risk of not being complied such as approval of all management policies being reserved to the Board.

To maximise compliance with the SOs, SoRD and Standing Financial Instructions (SFIs) the following way forward was presented to and supported by Audit Committee: to take the existing 124-page constitutional document and separate it into:

- SOs – with minor updates
- A simplified and significantly shorter SoRD, removing non-essential items such as the Accountable Officers Memorandum duties and Code of Conduct duties, which are duties rather than delegations and therefore not required in a SoRD.
- SFIs - no changes at this stage

A summary of the key changes to the SOs, SoRD and SFIs is set out below. Changes requested by Audit Committee have been made. Tracked changes and comments have been used to make changes quickly identifiable.

Impact: where significant implication(s) need highlighting

Non-compliance with the SoRD, SOs or SFIs places the organisation at risk of CQC censure, reputational damage and, whilst unlikely, NHSE enforcement action.

The simplified SoRD and Standing Orders have been developed with the assistance of the Good Governance Institute. To provide further independent assurance to the Board that the changes are sound, the proposed SoRD was reviewed by Hill Dickinson solicitors who advised that it is legally compliant.

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

Covered in Impact.

Report previously considered by & date(s):

Audit Committee 3 April 2023 and Trust Management Group 23 February 2023.

Recommendation	Board is asked to **APPROVE** the revised SOs; SoRD and SFIs

SUMMARY OF KEY CHANGES

Key changes / Update	Rationale
Scheme of Reservation and Delegation	
This is a fundamental re-drafting of the SoRD.	The SoRD is long and very hard to navigate which risks non-compliance.
The following non-essential items have been removed to shorten it and minimise duplication: • the Accountable Officers Memorandum duties • Codes of Conduct and Accountability duties • Delegation extracts from the SFIs • Delegation extracts from the SOs	 These are duties purely for the CEO and not required in a SoRD These are not powers and therefore do not need to be included in a SoRD. The SOs still stipulate the Codes need to be complied with. Plus there are a range of other duties that could equally be included but would add to the length/complexity of the document: Nolan Principles; Code of Governance etc. These are set out in the SFIs. Removed to shorten and to minimise duplication. These are set out in the SOs. Removed to shorten and to minimise duplication.
1.11 Establish the structure, terms of reference and reporting arrangements for sub-committees reporting to a Board Committee – *changed from reserved to Board to delegated to lead committee*	Sub-committee ToRs have not been going to Board. Brings into line with practice.
1.16 Discipline employees who are in breach of statutory requirements or SO's SoRD and SFIs. - C*hanged from reserved to Board to delegated to CEO*	To make it easier to take disciplinary action if needed without taking up valuable Board time.
NEW: 1.17 Monitor instances of failure to comply with SO's, SoRD and SFIs and recommend course of action where appropriate. – *delegated to Audit & Risk Committee (ARC)*	Enhancing governance
NEW: Approve detailed financial policies – *delegated to ARC*	For clarity
NEW: 1.20 Review decisions to suspend SO's SoRD and SFIs – *delegated to ARC*	Enhancing governance
NEW: 1.25 Authority to act for any matter not reserved to the Board or delegated to a Committee or Officer – *delegated to CEO* The Board has the authority to revert any such decision-making to the Board or a Committee.	To ensure action can be taken without needing to await a Board for any matter not explicitly reserved or delegated
NEW: 1.26 Compliance with the Accountable Officer Memorandum & 1.27 Compliance with the Codes of Conduct and Accountability.	Added so these remain highly visible
NEW: 2.5 Approve formal joint working arrangements with other organisations which involve decision-making, including established under section 75 of the 2006 NHS Act – *reserved to Board*	Added given the growing importance of system working and ensuring the Board has oversight

3.1 Approve the Trust's Annual Report and Annual Accounts - *delegated to ARC instead of reserved to Board*	Timings for submission means the Board can't review in ordinary Board and it is delegated to ARC. So this formalises reality.
NEW: 3.4 Approve the internal audit plan. – *delegated to ARC*	Clear delegation to ARC
3.6 Review the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements.	Delegated to Audit Panel rather than ARC on legal advice From 2017/18 onwards, NHS trusts must have an 'auditor panel' to advise on the appointment of their external auditors. Existing audit committees (or members of those committees) can be nominated to act as the panel with auditors excluded. [Extract from DoHSC Audit Panels – Guidance to help Health Bodies meet their Statutory Duties]
NEW 3.9: Approve and review a comprehensive system of internal control, including budgetary controls, that underpin the effective, efficient and economic operation of the Trust – *delegated to ARC*	Taken from NHSE's CCG model constitution SoRD
4.2 Confirm appointment of members of any committee of the Trust as representatives on outside bodies – *delegated to Chair and CEO, was reserved to Board*	To add flexibility.
4.3 Appoint and dismiss Executive Directors (subject to SO 2.2). – *delegated to RemCo.*	So that Executives are not involved in decisions relating to Executives. Appraise and discipline removed following Audit Committee feedback.
NEW 4.4 Appoint and dismiss the Trust Secretary.	Added following legal advice to comply with the Code of Governance.
5.1-5.8 - Approval of management policies – *see proposed delegations*	This is a significant change and warrants careful consideration. Currently reserved to the Board, but this risks non-compliance and Board spending disproportionate time vetting, approving and reviewing the c.200 policies of the Trust.
Approve the opening and closing of bank accounts. - *delegated to Chair and CEO, was reserved to Board*	An operational matter not needing Board time.
NEW 6.6 - Approve annual capital investment plan – *reserved to Board*	Added at request of DoF.
6.9 - Approve individual public and patient compensation payments over £30k. – *threshold of £30k added*	Currently all compensation payments reserved to Board – even £1, which doesn't warrant Board time. £30k recommendation from Director of Nursing.
NEW 7.3 - Approve the Trust's Quality Account – *reserved to Board*	A new requirement since the model SoRD.
NEW 7.4 - Propose arrangements, including supporting policies, to minimise clinical risk, maximize patient safety and to secure continuous improvement in quality and patient outcomes – *delegated to QSC*	Enhancing governance
NEW 7.5 - Receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans – *delegated to QSC*	Enhancing governance

NEW 7.6 - Monitor CNST standards and evidence compliance – *delegated to QSC*	Enhancing governance
NEW 7.7 - Receive an annual self-assessment of the Trust's performance rating using the CQC's assessment framework – *delegated to QSC*	Enhancing governance
8.3 - Approve the Trust's counter fraud and security management arrangements – *delegated to ARC instead of CEO & DoF*	It is more appropriate for the ARC to approve counter fraud arrangements rather than officers
8.4 - Approve proposals for action on litigation against or on behalf of the Trust – *delegated to Chief Executive or the lead Executive Director, instead of reserved to Board, with the Chair of Board informed*	Ensuring there is a SoRD that is realistic for workload/timeliness e.g. every CNST or LTPS where action is needed cannot realistically be reserved to the Board Audit Committee asked an additional control be added that the Chair of the Board is also informed. See 8.5 below for a further control
NEW 8.5 - Receive an annual report on litigation against or on behalf of the Trust – *delegated to ARC*	Given litigation is no longer reserved to the Board, this ensures Board Committee oversight of litigation
9.3 - All monitoring returns must be reported at least in summary to the Board, except where the Board delegates responsibility to a committee, in which case the monitoring return must be reported at least in summary to that committee.	Within existing SoRD but put onto a separate line to help ensure heeded
Standing Orders	
Changes to the SOs are limited, largely focussed on bringing the SOs up-to-date, in the context the model SOs were produced in 2006.	
A number of sections have been tidied, which do not change the substantive nature of the SOs. Only key changes are set out below.	
NEW: Re Board Composition SO 2.1(4) If the Trust's Establishment Order changes the Trust's status to a Teaching Hospital, then the Trust may have 12 members and up to 6 non-officer members plus the Chair of the Trust.	To enable moving to a Teaching Hospital without needing to change the Board composition
SO 2.7(2) Added to definition of the Chief Executive "As Accountable Officer, the Chief Executive has the responsibilities as set out in HM Treasury Guidance Managing Public Money, including ensuring that the trust acts in accordance with Establishment Order 2000 No 535."	To reflect the latest CEO duties
SO 3.1(2) Re Notice of papers to Board Allowing uploading the papers onto the Trust's approved Board and Committees papers online system with an email notice of publication to constitute service	Changing notice requirements to reflect the norms of electronic notice.
SO 3.17(i) Re When Private Board is allowed Changing so the Trust Secretary rather than FOI lead advises on what may be included in a Private Board meeting	Unclear why this was allocated to the FOI lead, given this is corporate governance.
NEW SO 4.8.4 Re approval of committee restructures - For the Board to consider and approve alterations to the committee structure only Standing Order 4.8, rather than all the Standing Orders, needs to be presented to	This keep paper length to the Board down.

the Board for approval. Approved changes will be incorporated into the Standing Orders.	
NEW SO 3.2 Re Emergency decision-making In exercising emergency powers, the Vice-Chair shall be able to deputise for the Chair in the Chair's absence within the bounds of SO 2.4(3). The Deputy Chief Executive or Executive Director formally covering the Chief Executive in his/her absence shall be able to deputise for the Chief Executive but only if the matter cannot await the return of the Chief Executive.	The SOs currently do not provide for a mechanism for emergency decision-making if the CEO is unavailable. Presumably, in the past it has been interpreted that the official deputy may deputise. But this removes any argument for whether this is legitimate and risk of judicial review.
NEW SO 5.4.4 Where a function is delegated to more than one director, each director may exercise that function in respect of matters or cases falling within the remit of the directorate or team for which they are a director.	For clarity.
NEW SO 5.4.5 A delegated function must be exercised in accordance with any statutory requirement which applies to the exercise of that function. This may include duties that apply generally to the exercise of functions by public and NHS bodies, such as the duty to have regard to the NHS Constitution (section 2 of the Health Act 2009) and the Public Sector Equality Duty (section 149 of the Equality Act 2010).	To ensure decision-making is legal.
NEW SO 5.6 "Only the Chief Executive may delegate matters delegated to him, whilst retaining overall responsibility. The Committees, Sub-committees, Executive and Non-Executive Members and employees to which a function has been delegated may not further delegate that function, unless specifically authorised to do so under this Scheme or as part of the delegation of that function."	Providing clarity and safeguarding against double-delegation
SO 6.2 Other NHS policy that must be read in conjunction with the SOs. Adding documents where there are important duties that need to be read in conjunction with the SOs. • Accountable Officer Memorandum • Codes of Conduct and Accountability • the Anti-Fraud and Bribery Policy • NHS Constitution • Code of Governance • Provider Licence	Modernising the constitution to reflect latest requirements / best practice. Most of these did not exist when the 2006 model SOs was produced, which the Trust's SOs are based on.
SO 6.4 Specific legal guidance Referencing new legislation: • Equality Act 2010 • Data Protection Act 2018 • Updating latest Caldicott guidance	Key legislation since model SOs added.
SO 7.4.1 Standards of Business Conduct Updated with latest conduct documents: • Those covered in 6.2 above plus • Code of Conduct for NHS Managers • the Nolan Principles on Conduct in Public Life	These are the latest national business conduct practice requirements

• Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England	
Standing Financial Instructions	
No changes – just moved into a separate document and re-numbered	SFIs are managed by Finance.

East and North Hertfordshire NHS Trust

TRUST-WIDE POLICY

for

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

A document recommended for use

In: Trust-wide

By: All staff

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

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

Written by: Trust Secretary
Financial Controller
Director of Procurement
Local Counter Fraud Specialist / Anti-Crime Specialist

Approved by:
Audit committee

Trust Ratification: Trust Board

Policy issued: ~~7 September 2022~~ 3 May 2023
To be reviewed before: ~~1 October 2023~~30 November 2024
To be reviewed by: Trust Secretary / Financial Controller
Doc Registration No. CG05 **Version No.** 1~~4~~3

Version	Date	Comment
1	2010	
2	2012	
3	2013	Scheduled review: Updated to reflect the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation. Loss and compensation section updated. Delegated Limits reviewed.
4	October 2014	Scheduled review – Minor changes. Delegated limits reviewed.
5	October 2015	Scheduled review. Revised to reflect Capital Review Group Update to include revised process regarding centralisation of documents on the KC; improved escalation process and inclusion of a wider range of documents
6	October 2016	Scheduled review. Revised to ensure supports Board meeting moving to bi- monthly, include the Auditor Panel and strengthen procurement.
7	October 2017	Scheduled review. Updated in line with Organisational changes.
8	October 2018	Scheduled review. Updated in line with Organisational changes.
9	October 2019	Scheduled review. Updated in line with Organisational changes.
10	October 2020	Scheduled review. Updated in line with Organisational changes.
11	October 2021	Scheduled review. Updated in line with Organisational changes.
12	May 2022	To enable a committee restructure
13	Sept 2022	For Audit Committee to become an Audit and Risk Committee
14	May 2023	Scheduled review. Separated documents to make them easier to use

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~~
Code of Governance
Provider Licence
NHS Constitution
Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England
Code of Conduct for NHS Managers

Review

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

Key messages

1. The ~~consolidated~~se -document~~s provides a single source of~~offset out 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. Powers that are reserved to the Board to delegated to committees or officers are set out in the Scheme of Reservation and Delegation.
4. Financial responsibilities and authorities are described in the SFIs and ~~SoDA~~ Detailed Limits of Delegation Policy
5. All employees of the Trust need to be aware of their responsibilities and authorities described in ~~this~~ these document~~s~~. Failure to comply with ~~this~~ these document~~s~~ is a disciplinary matter, which will be handled in accordance with the Trust's Disciplinary Policy. Where a breach constitutes a criminal offence, the matter may be subject to criminal investigation and will be handled in accordance with the Trust's Anti-Fraud and Bribery Policy and relevant legislation.

May 2023

INDEX

SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS, SCHEME OF RESERVATION AND DELEGATION AND STANDING FINANCIAL INSTRUCTIONS

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

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

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

1.2.2 **Trust** means the East and North Hertfordshire NHS Trust

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

1.2.4 **Bribery -** Giving or receiving a financial or other advantage in connection with the 'improper performance' of a position of trust, or a function that is expected to be performed impartially or in good faith. Where the Trust is engaged in commercial activity it could be considered guilty of a corporate bribery offence if an employee, agent, subsidiary or any other person acting on its behalf bribes another person intending to obtain or retain business or an advantage in the conduct of business for the Trust and it cannot demonstrate that it has adequate procedures in place to prevent such. The adequate procedures that the Trust is required to have in place to prevent bribery being committed on their behalf are performed by six principles – proportionate procedures, top-level commitment, risk assessment, communication (including training), monitoring and review. The Trust does not tolerate any bribery on its behalf, even if this might result in a loss of business for it. Criminal liability must be prevented at all times. Please see the Trust's Anti Fraud and Bribery Policy for a summary of the Bribery Act 2010.

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

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

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

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

1.2.9 ~~Clinical Governance~~Quality and Safety **Committee** means a committee whose functions are concerned with the arrangements for the purpose of monitoring and

improving the quality of healthcare for which the East and North Hertfordshire NHS Trust has responsibility.

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

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

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

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

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

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

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

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

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

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

1.2.20 **Nominated officer** means an officer charged with the responsibility for discharging specific tasks within Standing Orders, Scheme of Reservation and Delegation 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 and Social Care guidance.

1.2.25 **SFIs** means Standing Financial Instructions.

1.2.26 **SOs** means Standing Orders.

1.2.27 **SoRD** means Scheme of Reservation and Delegation.

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.

1.2.28 Within this document, unless the context otherwise requires:

a) words imparting any gender include any other;
b) words in the singular include the plural and words in the plural include the singular; and
c) a reference to an enactment is a reference to that enactment as amended.

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 Health and Care Act 2022 and any secondary legislation.

(3) The statutory functions conferred on the Trust are set out in the NHS Act 2006 (Chapter 3 and 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 Health and Care Act 2022 and any secondary legislation..

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

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

1.2 NHS Framework

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

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

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

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". ~~Delegated Powers are covered in 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 the Scheme of Reservation and Delegation, the Standing Financial Instructions and the Detailed Limits of Delegation Policy ~~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.

Commented [DS(ANHNT1]: Removed as duplicates the next sentence

1.4 Integrated Governance

Commented [DS(ANHNT2]: Co-operation duty

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

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

2.1 Composition of the Membership of the Trust Board

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

(1) The Chair of the Trust (Appointed by NHS ~~Improvement~~England);

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

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

- the Chief Executive;
- the Director of Finance

The Trust shall have not more than 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).

(4) If the Trust's Establishment Order changes the Trust's status to a Teaching Hospital, then the Trust may have 12 members and up to 6 non-officer members plus the Chair of the Trust.

Commented [DS(ANHNT3]: Added to allow for the necessary additional NED needed on the Board to represent the University/Teaching view.

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 and Health and Care Act 2022 provides that the Chair is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Trust's Chair and members are set out in the Membership, Procedure and Administration Arrangements Regulations.

2.3 Terms of Office of the Chair and Members

(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.

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

(3) **Director of Finance**

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

(4) **Non-Executive Members**

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

(5) **Chair**

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

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

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

2.8 Corporate role of the Board

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

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

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

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

2.9 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 'Schemedule of Matters Reservations and Delegationsed 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 Reservation and Delegation.

2.10 Lead Roles for Board Members

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

3. MEETINGS OF THE TRUST

3.1 Calling meetings

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

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

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

3.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three clear calendar days before the meeting. The notice shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf. Uploading the papers onto the Trust's approved Board and Committees papers online system with an email notice of publication will constitute service. Want of service of such a notice on any member shall not affect the validity of a meeting.

Commented [DS(ANHNT4]: No longer workable with an online paper system

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

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

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

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

3.3 Agenda and Supporting Papers

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

3.4 Petitions

Where a petition has been received by the Trust the Chair shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

(1) Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

(2) The notice shall be delivered at least 5 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

Subject to the agreement of the Chair, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

i) **Who may propose**

A motion may be proposed by the Chair of the meeting or any member present. It must also be seconded by another member.

ii) **Contents of motions**

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

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

iii) **Amendments to motions**

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

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

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

iv) **Rights of reply to motions**

a) Amendments

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

b) Substantive/original motion

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

v) **Withdrawing a motion**

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

vi) **Motions 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, Scheme of Reservation and Delegation and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

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

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

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

(iv) The Board may agree that its Members can participate in its meetings by telephone, teleconference and video or computer link. Participation in a meeting in this manner will be deemed to constitute a presence in person at the meeting.

3.12 Voting

(i) Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chair of the meeting) shall have a second, and casting vote.

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

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

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

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

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

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

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

3.13 Suspension of Standing Orders

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

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

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

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

3.14 Variation and amendment of Standing Orders

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

- upon a notice of motion under Standing Order 3.5;

- upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;
- that two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Officer members vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.15 Record of Attendance

The names of the Chair and Directors/members present at the meeting shall be recorded.

3.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be 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~~Trust Secretary to ensure correct procedure is followed on matters to be included in the exclusion.

(ii) **General disturbances**

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

- `That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act 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. For the avoidance of doubt, the Trust may choose to hold the meeting remotely online and transmit the meeting electronically.

3.18 Observers at Trust meetings

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

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

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

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

4.2 Joint Committees

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

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

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

(i) The Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust, except where SO 4.3(ii) and 4.4(ii) apply. In which case the term "Chair" is to be read as a reference to the Chair of other committee as the context permits, and the term "member" is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

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

4.4 Terms of Reference

(i) 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.

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

4.5 Delegation of powers by Committees to Sub-Committees

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

4.6 Approval of Appointments to Committees

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

4.7 Appointments for Statutory functions

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

4.8 Committees established by the Trust Board

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

4.8.1 **Audit and Risk Committee**

~~In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and more recently the Higgs report, a~~An Audit Committee will be established and constituted to provide the Trust Board with an independent and objective review of the Trust's system of internal control including its financial systems, financial information, assurance arrangements including clinical governance, risk management and compliance with legislation. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis. Assurances with regards to the ongoing management of risk are within the duties of the relevant sub-committee.

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

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

4.8.2 **Remuneration and Appointments Committee**

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

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

4.8.3 **Charitable Trustee Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Trust Board will establish a Trust and Charitable Trust Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

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

4.8.4 **Other Committees**

The Board may also establish such other committees as required to discharge the Trust's responsibilities. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis. For the Board to consider and approve alterations to the committee structure only Standing Order 4.8, rather than all the Standing Orders, needs to be presented to the Board for approval. Approved changes will be incorporated into the Standing Orders.

These additional committees currently ~~include~~are:

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

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

~~The Committee's work includes:~~

- ~~maintaining an overview of the development and maintenance of the Trust's medium and long term financial strategy;~~
- ~~providing scrutiny of operational performance;~~
- ~~monitoring workforce planning and establishment reviews;~~
- ~~overseeing risk management for the duties of the Committee.~~
- ~~monitoring and reviewing the Trust's strategic plans for IT/Digital and the Green Plan.~~

Commented [DS(ANHNT5]: Removed because the Board may choose to move functions between committees. Therefore, it is preferable to keep the purpose of a committee high level and the ToRs cover the detail.

ii) **Quality and Safety Committee**

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

iii) **Auditor Panel**

In line with the requirements of the Local Audit and Accountability Act 2014 the Trust has established an Auditor Panel to enable the Trust to meet its statutory duties by advising on the selection, appointment and removal of the External Auditors and on maintaining an independent relationship with them. The Terms of Reference are approved by the Trust Board and reviewed on a periodic basis. The committee is comprised of the Audit and Risk Committee Non-Executive Directors.

iv) **People Committee**

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

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 The National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and Health and Care Act 2022 allows for regulations to provide for the functions of Trusts to be carried out by third parties. In accordance with The Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (amended) the functions of the Trust may also be carried out in the following ways:

(i) by another Trust;

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

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

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

5.1.3 Where a function is delegated by these Regulations to another Trust, health body or local authority then that body exercises the function in its own right; the receiving body has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or officers, the Trust delegating the function retains full responsibility.

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

5.2 Emergency Powers and urgent decisions

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

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

Commented [DS(ANHNT6]: Added because the SOs only currently cover Chair absence and not Chief Exec

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

5.4.3 Nothing in the Scheme of Reservation and Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance to provide information and advise the Board in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

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

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

5.5 ~~Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers~~Scheme of Reservation and Delegation

5.5.1 The arrangements made by the Board as set out in the "Scheme of Reservation and Delegation" ~~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 Ability to Delegate Delegated Functions

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

5.~~6~~7 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the ~~Board~~ Audit and Risk Committee~~for action or ratification~~. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The Trust Board will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by East and North Hertfordshire NHS Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the ~~Standards of Business Conduct and~~ Managing Conflicts of Interests 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.
- Accountable Officer Memorandum
- Codes of Conduct and Accountability
- the Anti-Fraud and Bribery Policy
- NHS Constitution
- Code of Governance
- Provider Licence

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders, including the Detailed Limits of Delegation Policy.

Commented [DS(ANHNT7]: An appendix to the SFIs. Included for avoidance of doubt.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

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

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 **Requirements for Declaring Interests and applicability to Board Members**

i) The NHS Code of Accountability requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

ii) In addition to Board Members Declarations of Interest also applies to all Directors, both Executive and Non-Executive, Senior Managers (Divisional Directors, Divisional Chairs, agenda for change band 8d and above and the

Trust Secretary), Consultants and other Decision Making Staff – (all budget holders, administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions, who have the power to enter into contracts on behalf of Trust). As set out in the Managing Conflicts of Interest Policy.

7.1.2 **Interests which are relevant and material**

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

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

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

7.1.3 **Advice on Interests**

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

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

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

7.1.4 **Recording of Interests in Trust Board minutes**

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes.

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

7.1.5 **Publication of declared interests in Annual Report**

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

7.1.6 **Conflicts of interest which arise during the course of a meeting**

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

7.2 Register of Interests

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

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

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

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

7.3.1 **Definition of terms used in interpreting 'Pecuniary' interest**

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

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

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

(iii) "Pecuniary interest"

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

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

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

iv) Exception to Pecuniary interests

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

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

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

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

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

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

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

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

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

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

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

7.3.3 **Waiver of Standing Orders made by the Secretary of State for Health and Social Care**

(1) Power of the Secretary of State to make waivers

Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a Chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

(2) Definition of 'Chair' for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3.(3) (below), the "relevant Chair" is –

(a) at a meeting of the Trust, the Chair of that Trust;

(b) at a meeting of a Committee –

(i) in a case where the member in question is the Chair of that Committee, the Chair of the Trust;

(ii) in the case of any other member, the Chair of that Committee.

(3) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

(i) A member of the East and North Hertfordshire NHS Trust ("the Trust"), who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

(a) services under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and Health and Care Act 2022 and any secondary legislation; or

(b) services in connection with a pilot scheme under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and Health and Care Act 2022 and any secondary legislation;

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

(ii) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:-

(a) arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(b) has been declared by the relevant Chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:–

(i) are members of the same profession as the member in question,

(ii) are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(4) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant Chair must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3 (2) (b) above, except where that member is the Chief Executive;

(c) **in the case of a meeting of the Trust**:

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may not vote on any question with respect to it.

(d) **in the case of a meeting of the Committee:**

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may vote on any question with respect to it; but

(iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.4 Standards of Business Conduct

7.4.1 **Trust Policy and National Guidance**

All Trust staff and members of must comply with

- the Trust's Values
- ~~and Standards of Business Conduct and~~ Managing Conflicts of Interest Policy;
- Anti-Fraud and Bribery Policy
- ~~and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff' (see SO 6.2).~~
- the NHS Constitution
- Code of Conduct for NHS Managers
- the Code of Governance (except where the Trust agrees to explain in the annual report any non-compliance)
- the Provider Licence

In addition, Board members must comply with:

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

Commented [DS(ANHNT8]: Includes Gifts & Hospitality.

Commented [DS(ANHNT9]: The other conduct documents in this section supersede this old guidance

7.4.2 **Interest of Officers in Contracts**

i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust's Trust Secretary as soon as practicable.

ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 **Canvassing of and Recommendations by Members in Relation to Appointments**

i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4.4 **Relatives of Members or Officers**

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

ii) The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

iii) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' (SO 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 **Custody of Seal**

The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him/her in a secure place.

8.2 **Sealing of Documents**

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

8.3 **Register of Sealing**

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 **Signature of documents**

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Detailed Scheme of Delegation Policy but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

9. MISCELLANEOUS (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 Health and Care Act 2022 and any secondary legislation. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and Health and Care Act 2022 and any secondary legislation.

See overlap with Standing Financial Instruction No. 21.3.

SCHEME OF RESERVATION AND DELEGATION (SoRD)

1. PURPOSE

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

2. INTRODUCTION

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

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

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

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

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

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

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

3. SCOPE

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

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

SCHEME OF RESERVATION AND DELEGATION (SoRD)

4. SCHEME OF RESERVATION AND DELEGATION

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
1. Regulation and Control	1.1	Approve this Scheme of Reservation and Delegation (SoRD), Standing Orders (SO's) and Standing Financial Instructions (SFI's).	✓		The scheme is reviewed by the Audit & Risk Committee.
	1.2	Suspend, vary or amend SO's, SFI's or the SoRD.	✓		
	1.3	Execute Emergency/urgent Powers reserved to the Board outside of Board meetings.		Chair and Chief Executive	At least two non-executive directors must be consulted.
	1.4	Ratify any emergency/urgent decisions of matters reserved to the Board or its Committees taken outside of Board meetings under SO 5.2. Emergency/urgent decisions must be reported to the next Board meeting.	✓		Standing Order 5.2
	1.5	Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.	✓		
	1.6	Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and on which to take appropriate action.	✓		
	1.7	Confirm the recommendations of the Trust's committees where the committees do not have executive powers.	✓		
	1.8	Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.	✓		
	1.9	Determine the Board's committee structure.	✓		
	1.10	Establish terms of reference and reporting arrangements for all committees ~~and sub committees~~ that are established by the Board, including responsibilities (in line with legal requirements).	✓		
	1.11	Establish the structure, terms of reference and reporting arrangements for sub-committees reporting to a Board Committee (excluding executive powers which only the Board can delegate – see 1.12).		Any Committee of the Board, for their sub-committees	
	1.12	Delegate executive powers to sub committees i.e. a committee cannot approve/delegate executive powers to one of its sub-committees without Board approval.	✓		

Commented [DS(ANHNT1]: New. Although in SOs.

Commented [DS(ANHNT2]: Amended – never happened. Instead created 1.11

Commented [DS(ANHNT3]: NEW – previously reserved to the Board but this has not happened

2

SCHEME OF RESERVATION AND DELEGATION (SoRD)

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
1. Regulation and Control (continued)	1.13	Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.	✓		
	1.14	Approve the establishment of a subsidiary company and the associated articles of association and operating framework.	✓		
	1.15	Discipline members of the Board who are in breach of statutory requirements or SO's SoRD and SFIs.	✓		
	1.16	Discipline employees who are in breach of statutory requirements or SO's SoRD and SFIs.		Chief Executive	
	1.17	Monitor instances of failure to comply with SO's, SoRD and SFIs and recommend course of action where appropriate.		~~Audit & Risk Committee~~	~~Standing Order 5.6~~
	1.18	Approve detailed financial policies.		Audit & Risk Committee	
	1.19	Final authority in interpretation of SO's SoRD and SFIs.		Chair	Advised by the Chief Executive and Head of Corporate Governance
	1.20	Review decisions to suspend SO's SoRD and SFIs.		Audit & Risk Committee	
	1.21	Maintain the Register of Interests.		Head of Corporate Governance	
	1.22	Maintain an effective system of financial control.		Director of Finance	
	1.23	Approve proposed prepayment arrangements.		Director of Finance	
	1.24	Authorise the use of the seal.		Chief Executive	Standing Order 8
	1.25	Authority to act for any matter not reserved to the Board or delegated to a Committee or officer. The Board has the authority to revert any such decision-making to the Board or a Committee.		Chief Executive	
	1.26	Compliance with the Accountable Officer Memorandum.		Chief Executive	
	1.27	Compliance with the Codes of Conduct and Accountability.	✓ (individually)		

Commented [DS(ANHNT4]: New – employees were previously reserved to the Board but discipline decisions of individual employees was not going to the Board

Commented [DS(ANHNT5]: New – to enhance governance

Commented [DS(ANHNT6]: New

Commented [DS(ANHNT7]: New

Commented [DS(ANHNT8]: New – to enhance governance

SCHEME OF RESERVATION AND DELEGATION (SoRD)

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
2. Meetings of the Trust	2.1	Call Meetings.		Chair	
	2.2	Chair all Board meetings and associated responsibilities.		Chair	
	2.3	Give final ruling in questions of order, relevancy and regularity of meetings.		Chair	
	2.4	Having a second or casting vote.		Chair	
	2.5	Approve formal joint working arrangements with other organisations which involve decision-making, including established under section 75 of the 2006 NHS Act.	✓		
3. Annual Reports, Accounts and Audit	3.1	Approve the Trust's Annual Report and Annual Accounts as well as other financial statements of the Trust and any formal announcements relating to the trust's financial performance.		Audit & Risk Committee	
	3.2	Approve the Annual Report and Accounts for funds held on trust.	✓		
	3.3	Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate.	✓	Audit & Risk Committee	
	3.4	Approve the internal audit plan.		Audit & Risk Committee	
	3.5	Approve of external auditors' arrangements, including a review of independence and objectivity, for the separate audit of funds held on trust.		Audit Panel	
	3.6	Review the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements.		Audit Panel	
	3.7	Review the annual management letter received from the external auditor and agree proposed action.		Audit & Risk Committee	
	3.8	Ensure an adequate internal audit service is provided by reviewing the trust's internal financial controls and internal control and risk management systems.		Director of Finance	
	3.9	Approve and review a comprehensive system of internal control, including budgetary controls, that underpin the effective, efficient and economic operation of the Trust.		Audit & Risk Committee	

Commented [DS(ANHNT9]: NEW: needed for system-working & as a safeguard

Commented [IL10]: More in line with the Code of Governance

Commented [DS(ANHNT11]: Was reserved to Board. Changed to ARC because Board timings mean the Board have to delegate approval to ARC. Wording amended following legal advice

Commented [DS(ANHNT12]: New – surprising omission from the Model template given the importance of internal audit

Commented [IL13]: This is more in line with the Code of Governance

Commented [DS(ANHNT14R13]: Solicitor advice accepted

Commented [DS(ANHNT15]: Changed for ARC to Audit Panel on legal advice

Commented [DS(ANHNT16]: NEW. Taken from CCG's model constitution.

SCHEME OF RESERVATION AND DELEGATION (SoRD)

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
4. Workforce	4.1	Appoint the Vice Chair of the Board.	✓		
	4.2	Confirm appointment of members of any committee of the Trust as representatives on outside bodies.		Chair and Chief Executive	
	4.3	Appoint and dismiss Executive Directors (subject to SO 2.2).		Remuneration Committee	
	4.4	Appoint and dismiss the Trust Secretary.		Remuneration Committee	
	4.5	Determine the broad remuneration policy and performance management framework and to set individual remuneration arrangements for the Trust's Executive Directors.		Remuneration Committee	
	4.6	Approve any termination arrangements for executive directors.		Remuneration Committee	
	4.7	Review and approve the remuneration framework for subsidiary companies of the Trust.		Remuneration Committee	
	4.8	Approve proposals presented by the CPO for setting remuneration and terms and conditions of employment for those employees and officers not covered by Agenda for Change or the Remuneration Committee, within agreed budgets and subject to relevant Workforce Policies.		People Committee	
5. Policies		Approval of management policies with the following reservations and delegations:			
	5.1	• Constitutional policies (including Standing Orders) • Policies reserved to the Board due to their sensitivity or public relations implications: Complaints; Risk; Freedom to Speak Up; Whistleblowing; Emergency Planning & Business Continuity; H&S.	✓		
	5.2	• Financial, corporate governance (non-constitutional) and legal policies • Information Governance policies.		Audit Committee	

Commented [DS(ANHNT17]: Was reserved to the Board. But this has not been happening. Therefore, delegated to the Chair and Chief Executive.

Commented [DS(ANHNT18]: Currently reserved to Board but RemCo has been fulfilling this function. Therefore, proposing move to RemCo.

Commented [IL19]: It would be helpful to ensure that there is oversight on secretaries

Commented [DS(ANHNT20R19]: Accepted Solicitor recommendation of this new delegation given this is a requirement in the Code of Governance

Commented [DS(ANHNT21]: Approval of management policies was previously reserved to the Board

SCHEME OF RESERVATION AND DELEGATION (SoRD)

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
5. Policies (continued)	5.3	Approval of clinical, quality & safety policies which measure and monitor clinical governance, clinical effectiveness and outcomes, research governance, health inequalities, health & safety, patient and public safety, compliance with CQC regulation and some workforce issues relating to workforce capability and development, such education and talent management (except where delegated to sub-committees below).		Quality & Safety Committee	
	5.4	Medicines Management.		Therapeutics policies sub-committee	
	5.5	Competencies.		Clinical skills sub-committee	
	5.6	• People (HR) policies. • Facilities & Estates.		Chief Executive	
	5.7	Any policies not expressly reserved or delegated are delegated to the CEO, who may delegate a specified officer.		Chief Executive	
	5.8	Change to Policies so adopted shall be listed and held by senior officer responsible for policy management.		Chief Nurse	
6. Strategy, Plans and Budgets	6.1	Define the strategic aims and objectives of the Trust.	✓		
	6.2	Approve annual financial plan.	✓		
	6.3	Ratify proposals for acquisition, disposal or change of use of land and/or buildings.	✓		
	6.4	Approve PFI proposals re-financing.	✓		
	6.5	Approve the opening and closing of bank accounts.		Chief Executive plus Director of Finance	
	6.6	Approve annual capital investment plan.	✓		
	6.7	Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a 3 year period or the period of the contract if longer.	✓		
	6.8	Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive	✓		

Commented [IL22]: This would be more in keeping with the Code of Governance

Commented [DS(ANHNT23R22]: Solicitor wording changes accepted

Commented [DS(ANHNT24]: Amended because only PFI re-financing proposals are now allowed

Commented [DS(ANHNT25]: Was reserved to Board but risks non-compliance

Commented [DS(ANHNT26]: New – recommended by DoF

SCHEME OF RESERVATION AND DELEGATION (SoRD)

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
		and Chief Financial Officer (for losses and special payments) previously approved by the Board.			
	6.9	Approve individual patient and public compensation payments over £30k. All other compensation payments are delegated to the CEO (who may delegate further within the detailed SFIs)	✓		
	6.10	Review use of NHS Resolution risk pooling schemes (LPST/CNST/RPST).	✓		
	6.11	Approve plans for applications for short-term or longer term borrowings or loans	✓		
	6.12	Approve a list of employees authorised to make short term borrowings on behalf of the Trust (this must include the Chief Executive and the Chief Financial Officer)	✓		
7. Quality and Safety	7.1	Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State.	✓		
	7.2	Approve the Trust's arrangements for handling complaints.	✓		
	7.3	Approve the Trust's Quality Account.	✓		
	7.4	Propose arrangements, including supporting policies, to minimise clinical risk, maximize patient safety and to secure continuous improvement in quality and patient outcomes.		Quality & Safety Committee	
	7.5	Receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans.		Quality & Safety Committee	
	7.6	Monitor CNST standards and evidence compliance.		Quality & Safety Committee	
	7.7	Receive an annual self-assessment of the Trust's performance rating using the CQC's assessment framework.		Quality & Safety Committee	

Commented [DS(ANHNT27]: Previously any compensation (even £1) reserved to Board. Risked non-compliance.

Commented [DS(ANHNT28]: SFI 22.1.1

Commented [DS(ANHNT29]: New

Commented [DS(ANHNT30]: New. Taken from CCG model constitution.

Commented [DS(ANHNT31]: New – enhanced governance

Commented [DS(ANHNT32]: New – in light of learning re CNST

Commented [DS(ANHNT33]: New – proposed enhancement

SCHEME OF RESERVATION AND DELEGATION (SoRD)

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
8. Operational and Risk Management	8.1	Approve the Trust's policies and procedures for the management of risk.	✓		
	8.2	Approve arrangements for risk sharing and/or risk pooling with other organisations (for example arrangements for pooled budget arrangements under section 75 of the NHS Act 2006).	✓		
	8.3	Approve the Trust's counter fraud and security management arrangements.		Audit Committee	
	8.4	Approve proposals for action on litigation against or on behalf of the Trust. Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or the lead Executive Director.		Chief Executive or the lead Executive Director, with Chair of Board informed	
	8.5	Receive an annual report on litigation against or on behalf of the Trust.		Audit Committee	
9. Monitoring	9.1	Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated and fulfilment of responsibilities.	✓		
	9.2	Continually appraise the affairs of the Trust by means of the provision of information to the Board as the Board may require from directors, committees, and officers of the Trust, including any reporting to Board required in policies.	✓		
	9.3	All monitoring returns must be reported at least in summary to the Board, except where the Board delegates responsibility to a committee, in which case the monitoring return must be reported at least in summary to that committee.	✓	Or Lead Committee (but only where explicitly delegated in the Terms of Reference)	
	9.4	Receive reports from Chief Financial Officer on financial performance against budget and annual business plan.	✓		
	9.5	Receive reports from Chief Executive on performance matters by exception.	✓		

Commented [DS(ANHNT34]: Was Chief Exec and DoF. Changed to Audit Committee.

Commented [DS(ANHNT35]: Was reserved to the Board. However, risks non-compliance. But to ensure oversight introducing an annual report on litigation to Audit Committee. Chair informed added at request of Audit Committee.

Commented [DS(ANHNT36]: NEW – as per above

Commented [DS(ANHNT37]: NEW – enhanced governance

Commented [DS(ANHNT38]: Separated to ensure this requirement is not overlooked

East and North Hertfordshire NHS Trust

SECTION D STANDING FINANCIAL INSTRUCTIONS

SECTION D - STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1 General

1.1.1 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).

1.1.2 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.

1.1.3 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.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.5 **The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

1.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Risk Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.2 Responsibilities and delegation

1.2.1 **The Trust Board**

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

1.2.2 The Trust Secretary holds a record of circumstances that the Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. All other powers have been delegated to such other committees as the Trust has established.

1.2.3 **The Chief Executive and Director of Finance**

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.4 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

1.2.5 **The Director of Finance**

The Director of Finance is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.2.6 **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.2.7 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.2.8 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.

2. AUDIT

2.1 Audit and Risk Committee

2.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2018), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

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

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

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

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

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

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

2.1.2 Where the Audit and Risk Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit and Risk Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need

to be referred to the Department of Health. (To the Director of Finance in the first instance.)

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

2.2 Director of Finance

2.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud, bribery or corruption, and in conjunction with the Local Counter Fraud Specialist (LCFS) / Anti-Crime Specialist (ACS) and NHS Counter Fraud Authority in cases of fraud, bribery or corruption;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit and Risk Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

2.2.2 The Director of Finance, designated auditors and LCFS are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

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

2.3.4 The audit manager shall be accountable to the Audit and Risk Committee though the Head of Internal Audit and shall report to the Director of Finance for the operational delivery. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit and Risk Committee and the audit manager. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every three years.

2.3.5 The LCFS will be notified where the internal audit function identifies inadequacy of poor application of financial and other management controls which may present a risk of fraud, bribery or corruption occurring.

2.4 External Audit

2.4.1 The External Auditor is appointed following a selection and appointment process overseen by the 'Auditor Panel'. The Audit and Risk Committee will be responsible for the effectiveness of the external audit function and will receive reports from the external audit partner. The contract will be reviewed at least every three years. If there are issues with the external audit, these should be raised with the external auditor in the first place. If the removal of the external auditor is considered, the 'Auditor Panel' will need to be convened and a recommendation made to the Board.

2.5 Fraud, Bribery and Corruption

2.5.1 In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with the NHS Standard Contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority requirements in accordance with the Government Counter Fraud Functional Standards.

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

2.5.3 The Trust shall nominate a professionally accredited Local Counter Fraud Specialist (LCFS) / Anti-Crime Specialist (ACS) to conduct the full range of anti-fraud, bribery and corruption work on behalf of the Trust as specified in the NHS Counter Fraud Authority requirements in accordance with the Government Counter Fraud Functional Standards.

2.5.4 The LCFS shall report to the Director of Finance and shall work with staff in NHS Counter Fraud Authority, in accordance with the NHS Counter Fraud Authority Government Counter Fraud Functional Standards, the NHS Counter Fraud Manual and the NHS Counter Fraud Authority's Investigation Case File Toolkit.

2.5.5 If it is considered that evidence of offences exist and that a prosecution is appropriate, the LCFS/ACS will consult with the Director of Finance to obtain the necessary authority and agree the appropriate route for pursuing any action i.e. referral to the police or to the NHS Counter Fraud Authority.

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

2.5.7 The LCFS will ensure that measures to mitigate against identified risks are included within an organisational work plan which ensures that an appropriate of resource is available to the level of any risks identified. Work will be monitored by the Director of Finance and outcomes reported to the Audit and Risk Committee.

2.5.8 In accordance with the Raising Concerns at Work (Freedom to Speak Up) Policy, the Trust shall have a whistleblowing mechanism in place to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national NHS fraud and corruption reporting line, as provided by the NHS Counter Fraud Authority.

2.5.9 The Trust will report annually on how it has met the standards as set out by the NHS Counter Fraud Authority in relation to anti-fraud, bribery and corruption work and the Director of Finance and Audit and Risk Committee Chair shall sign-off the annual self-review and authorise its submission to the NHS Counter Fraud Authority.

2.6 Security Management

2.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

2.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

3. RESOURCE 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.

4. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

4.1 Preparation and Approval of Plans and Budgets

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

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

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

4.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Plan

(b) accord with workload and manpower plans;

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

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

(e) identify potential risks.

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

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

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

4.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

4.2 Budgetary Delegation

4.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

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

4.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

4.3 Budgetary Control and Reporting

4.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) Movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

4.3.2 Each Budget Holder is responsible for ensuring that:

(a) Value for money is obtained from the use of resources, ensuring that these are used to obtain economy and effectiveness for the Trust

(b) Resources are not spent unnecessarily even if the appropriate budget exists

(c) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(d) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(e) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

4.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Trust's plans and a balanced budget.

4.4 Capital Expenditure

4.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 24).

4.5 Monitoring Returns

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

5. ANNUAL ACCOUNTS AND REPORTS

5.1 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and 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.

5.2 The Trust's annual accounts must be audited by the appointed external auditor. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

5.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Manual for Accounts.

6. BANK AND GOVERNMENT BANKING SERVICE (GBS) ACCOUNTS

6.1 General

6.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements, developing a cash and treasury management policy and for advising the Trust on the provision of banking services and operation of accounts. This may include operating through a shared business service. It will take into account guidance/ 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.

6.1.2 The Board shall approve the banking arrangements.

6.2 Bank and GBS Accounts

6.2.1 The Director of Finance is responsible for:

(a) 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.

6.3 Banking Procedures

6.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

(c) the use of shared business service.

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

6.4 Tendering and Review

6.4.1 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

6.4.2 Competitive tenders should be considered at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

7. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 Income Systems

7.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

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

7.2 Fees and Charges

7.2.1 The Trust shall comply with Department of Health 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.

7.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health 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.

7.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.2.4 The Director of Finance will put in place such systems and processes necessary to ensure that income due from transactions is recorded and accounted for in a timely and effective way.

7.3 Debt Recovery

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

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

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

7.4 Security of Cash, Cheques and other Negotiable Instruments

7.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

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

7.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

7.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7.5 2003 Money Laundering Regulations

Under no circumstances will the Trust accept cash payments 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.

8. TENDERING AND CONTRACTING PROCEDURE

8.1 General

The Trust shall use Hertfordshire and West Essex ICS NHS Procurement Services for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be

documented. If the Trust does not use Hertfordshire and West Essex ICS NHS Procurement Services the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

8.2 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

8.3 Governing Public Procurement

For public procurements commenced and not completed before 31 December 2020, Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

For public procurement commenced after 1 January 2021, the World Trade Organisation's (WTO) Government Procurement Agreement (GPA) promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

8.4 Reverse eAuctions

Reverse eAuctions will be conducted in accordance with Trust policy and procedures in place for the control of all tendering activity carried out through this process.

8.5 Capital Investment and other Department of Health Guidance

The Trust shall comply with the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts, including delegated limits, issued by 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.

8.6 Formal Competitive Tendering

8.6.1 **General Applicability**

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

8.6.2 **Health Care Services**

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 18 and No. 19.

8.6.3 **Exceptions and instances where formal tendering need not be applied**

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the amounts set out in the procurement scheme of delegation. (see appendix to this report)

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

8.6.4 **Building and Engineering Construction Works**

Competitive Tendering cannot be waived for building and engineering construction works and maintenance unless permitted under Department of Health Estates and Facilities guidance which may require specific Department of Health Approval.

8.6.5 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

8.7 Contracting/Tendering Procedure

8.7.1 **Invitation to tender –**

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

(a) Submitted electronically on the e- Procurement portal Atamis

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

(v) Where a feasibility study is required this must be conducted by an independent agency; in common with all procurements a tender should be issued with the Trust's exact requirements to potential bidders to enable them to produce a design with the associated costs, thus giving all potential bidders a fair and level platform with which to submit their bids for the tender.

8.7.2 **Receipt and safe custody of tenders**

The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening electronically.

The date and time of receipt of each tender shall be endorsed on the e-tendering System or endorsed on the unopened tender envelope/package.

8.7.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened Electronically via the e-Tendering portal Atamis.

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

(iii) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(iv) Every tender received shall be marked electronically with the date of opening.

(v) A register shall be maintained by the Chief Executive, or a person authorised by him, to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- each entry to this register shall be signed by those present.

(vi) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Order No. 8.6.5 below).

8.7.4 **Admissibility**

(i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

8.7.5 **Late tenders**

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential,.

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

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(ii) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection.

8.7.7 Invitation to tender – Electronic Process

(i) All tenders will be undertaken through the Atamis electronic tendering system. This shall enable: The required levels of calls for competition; a supplier information database; a process to request for prequalification information; evaluation of expressions of interest & prequalification questionnaires; creation of quotation/tender documents; invitation to tender; receipt of tenders; opening procedures evaluation award; contract management; and archiving of tender documentation

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 .

The Director of Procurement (Hertfordshire and West Essex ICS NHS Procurement Services) as guardian for the Atamis system is responsible for ensuring all tenders are treated as confidential and retained for inspection. The system provides a register of: the name of all firms or individuals invited to tender; the names of firms or individuals from which tenders have been received; the date the tenders were opened; and the price shown on each tender.

(iv) There is generally no discretion to receive tenders after the due date. In exceptional circumstances the Director of Procurement (Hertfordshire and West Essex ICS NHS Procurement Services) may request the Chief Executive to approve the inclusion of a late tender. The request will include an explanation of the exceptional circumstance and assurance that the tender process has not been compromised.

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

Where only one tender is sought and/or received, the Chief Executive and Finance Director shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

Any discussions with a tenderer which are deemed necessary to clarify technical aspects of the tender before the award of a contract will not disqualify the tender.

The most economically advantageous tender shall be accepted as determined by the tender evaluation criteria set by the tender project team at the start of the tender process.

No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Executive.

The use of these procedures must demonstrate that the award of the contract was not in excess of the going market rate / price current at the time the contract was awarded; and that best value for money was achieved.

(vi) The Director of Procurement (Hertfordshire and West Essex ICS Procurement Services) as the Chief Executive nominated officer responsible for tendering will report to the Trust Board on an exceptional circumstance basis as required by the Chief Executive.

8.7.8 **Tender reports to the Trust Board**

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

8.8 Quotations: Competitive and non-competitive

8.8.1 **General Position on quotations**

Quotations are required where formal tendering procedures are not adopted because the intended expenditure or income does not exceed the amounts set out in the scheme of delegation.

8.8.2 **Quotations**

(i) Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(ii) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(iii) All quotations should be treated as confidential and should be retained for inspection.

(iv) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

8.8.3 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

8.9 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the staff as set out in the Trusts' procurement scheme of delegation (as per appendix 1 to this report).

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

8.10 Private Finance for capital procurement (see overlap with SFI No. 24)

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

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

(b) Where the sum exceeds delegated limits, a business case must be referred to NHSI for approval or treated as per current guidelines.

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

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

8.11 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) any relevant statutory provisions;

(c) any relevant directions including NHSI Capital Investment guidance and Estate code;

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

8.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

8.13 Healthcare Services Agreements (see overlap with SFI No. 18)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

8.14 Disposals (See overlap with SFI No. 26)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the procurement policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

8.15 In-house Services

8.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

8.15.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a procurement officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £1m, a non-officer member should be a member of the evaluation team.

8.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

8.15.4 The evaluation team shall make recommendations to the Board.

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

8.16 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 29)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

9. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 17.13)

9.1 Service Level Agreements (SLAs)

9.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within future plans and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;

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

9.2 Involving Partners and jointly managing risk

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

9.3 Commissioning

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

9.4 Reports to Board on SLAs

The Chief Executive, as the Accountable Officer, will ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

10. THIS SECTION IS NOT APPLICABLE TO NHS TRUSTS

11. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

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

11.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Appointments Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

11.1.2 The Committee will make recommendations to the Board on the remuneration and terms of service for the Chief Executive and other Executive Directors and those staff that are not covered by Agenda for Change or Medical and Dental Terms and Conditions; to monitor and evaluate the performance of Executive Directors and to oversee contractual arrangements, including proper calculation and scrutiny of termination payments.

The Committee will also review and approve the Remunerations Framework for subsidiary companies of the Trust.

11.1.3 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.

11.1.4 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.

11.1.5 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.

11.2 **Funded Establishment**

11.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

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

11.3 Staff Appointments

11.3.1 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.

11.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

11.4 Processing Payroll

11.4.1 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.

11.4.2 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.

11.4.3 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.

11.4.4 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.

11.5 Contracts of Employment

11.5.1 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.

12. NON-PAY EXPENDITURE

12.1 Delegation of Authority

12.1.1 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.

12.1.2 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.

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

12.1.4 Where the Trust has approved systems for obtaining goods and services, such as i-Procurement, Pharmacy systems or materials management systems, all officers and managers are required to use those systems. Contravention of systems must be supported by a waiver, which will be reported to the Audit and Risk Committee.

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

12.2.1 **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.

12.2.2 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. 12.2.4 below.

12.2.3 **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.

12.2.4 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.

12.2.5 **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.

12.2.6 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

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

12.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act **shall** comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

13. EXTERNAL BORROWING

13.1.1 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.

13.1.2 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.

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

13.1.4 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.

13.1.5 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.

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

13.2 INVESTMENTS

13.2.1 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.

13.2.2 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.

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

14. FINANCIAL FRAMEWORK

14.1 The Director of Finance should ensure that members of the Board are aware of the Financial Framework. The Trust's medium term and longer-term financial strategy, the planned sources of funding including any external borrowing and repayment plan.

15. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 Capital Investment

15.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges;

(d) shall ensure that there is consultation with commissioners regarding capital investment of a strategic nature, or which has a material affect on income streams

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

(a) that a business case (in line with the guidance issued by 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.

15.1.3 Capital Review Group, (reports to the FPPC through the Director of Finance report) , meets on a monthly basis and performs the following functions:

(a) Considers applications for capital investment from Divisions and Corporate Directorates against risk of non-investment;

(b) Draws up a proposed capital programme for the next year for discussion and agreement at the FPPC;

(c) Sets the capital budgets following approval by FPPC;

(d) monitors progress of capital projects against budget;

(e) reports to the FPPC on progress made on capital projects after each meeting

(f) liaises with Divisions and Project Sponsors to aid the progression and management of capital schemes

(g) monitors the procurement of donated assets valued over £100k and reports to the Charity Trustee Committee

(h) review all capital risks at the Trust

(i) ensures that the Capital Resource Limit (CRL is achieved at the Trust)

(j) to review and verify assets held at the Trust ensuring that the Trust Asset register is accurate.

15.1.4 Business cases presented to the Deputies Group and Capital Review Group should consider sources of funding including purchase, private or other finance and lease funding. The Trust uses Lifecycle Group Limited to support the management of its lease portfolio. All lease proposals must be organised by Lifecycle unless the Finance, Performance and People Committee specifically agree alternative arrangements. Lifecycle recommendations will be reviewed by the user department and by Finance, but lease agreements can only be authorised in accordance with the Trust's Authorised Signatories for Lease Documentation.

15.1.5 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.

15.1.6 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.

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

15.1.8 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

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

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

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

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

(a) specific authority to commit expenditure;

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

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

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

15.1.12 The Deputy Directors' Group shall review all business cases at each of the three key stages – Strategic Outline Case, the Outline Business Case, the Full Business Case. This is to support business decisions are taken which support the strategic objectives, support the development and sustainability of quality services; are in line with the Trust's core strategies; are based on the best available intelligence; are fully impact assessed; are made within the context of the developing market and the existing and potential partnerships which could be developed to best exploit this market.

The Deputy Directors' Group will report its recommendations to the Executive/Divisional Executive committee and the business cases recommended for approval will be submitted to the Committee with the right level of authorisation as defined in the terms of reference.

15.1.13 The Finance, Performance and People Committee will evaluate, scrutinise and approve individual investment decisions including a review of Outline and Full Business Cases where there is:

(a) a capital scheme (including leased assets) with an investment value in excess of £500k

(b) all proposed fixed asset disposals where the value of the asset exceeds £500k

Where the scheme in question is in excess of £1 million, the Finance, Performance and People Committee will make a recommendation to the Trust Board, who will ultimately make a decision on the proposal

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

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

15.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its 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.

15.3 Asset Registers

15.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

15.3.2 The minimum data set to be held within the Trust's register shall be sufficient to identify, locate and value assets appropriately.

15.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) Notification of project completion by the relevant project manager who is responsible for ensuring properly 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.

15.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate) that are the responsibility of the relevant budget-holder.

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

15.3.6 The value of each asset shall be measured at its fair value in accordance with Trust's accounting policies.

15.3.7 The value of each asset shall be depreciated using methods and rates as specified to reflect the consumption of the assets economic useful life in accordance with the Trust's accounting policies.

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

15.4 Security of Assets

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

15.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

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

15.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss, including through theft, damage or obsolescence, of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses. A summary of such losses will be reported to the Audit and Risk Committee at least twice a year.

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

16. STORES AND RECEIPT OF GOODS

16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any

Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

16.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

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

16.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance the value of all losses and any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 16 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.3 Goods supplied by NHS Supply Chain

16.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note. Any discrepancies should be reported to NHS Supply Chain. The Director of Finance shall satisfy himself that the goods have been received before accepting the recharge.

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

17.1 Disposals and Condemnations

17.1.1 **Procedures**

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

17.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

17.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 **Procedures**

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

17.2.2 Any employee or officer discovering or suspecting a loss of any kind must refer to the Trust's Anti-Fraud and Bribery Policy and either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud, bribery and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant LCFS/ACS who will decide, in consultation with the Director of Finance. The External Auditor will be notified of all frauds. All fraud investigations will be reported to the NHS Counter Fraud Authority and Audit and Risk Committee.

17.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Board,

(b) the External Auditor.

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

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

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

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

17.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

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

17.2.10 Approval of requests for write off of bad debts will be subject to the detailed Scheme of Delegation in the Appendix to this document. All bad debts written off must be reported to the next meeting of the Losses and Special Payments Committee, which must report to the Audit and Risk Committee on a twice-yearly basis.

17.2.11 Under delegated powers the Losses and Special Payments Committee can approve payments to patients, staff and members of the public in respect of approved personal property claims up to the delegated limit without recourse to the Director of

Finance. These claims will form part of the twice-year report to Audit and Risk Committee.

18. INFORMATION TECHNOLOGY

18.1 Responsibilities and duties of the Director of Finance

18.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

18.1.2 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

18.1.3 The 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.

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

18.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

18.3 Contracts for Computer Services with other health bodies or outside agencies

The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy,

completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

18.4 Risk Assessment

The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

18.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

19. PATIENTS' PROPERTY

19.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

19.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; ***(notices are subject to sensitivity guidance)***
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

19.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

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

19.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

19.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

19.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

20. FUNDS HELD ON TRUST

20.1 Corporate Trustee

(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.

20.2 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.

20.3 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.

21. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Trust Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff; Managing Conflicts of Interest Policy. This policy follows the national guidance on Managing Conflicts of Interest in the NHS 2017and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

22. PAYMENTS TO INDEPENDENT CONTRACTORS

Not applicable to NHS Trusts.

23. RETENTION OF RECORDS

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

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

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

24. RISK MANAGEMENT AND INSURANCE

24.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health 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.

24.2 Insurance: Risk Pooling Schemes administered by NHS Resolution

The Board shall decide if the Trust will insure through the risk pooling schemes administered by NHS Resolution or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

24.3 Insurance arrangements with commercial insurers

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

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

(1) Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Appendix 1

Detailed Procurement Process

Introduction

In deciding what goods and services to procure, the Trust must be able to demonstrate that it has obtained Value for Money and compliant with Public Procurement regulations. In all cases of doubt in the procedure to be adopted, The Trust's Procurement service provider should be consulted. The procedure below outlines the process to be followed only and does not cover who would be responsible for signing any resultant Purchase Order – these levels are covered in Appendix 2.

Exceptions from competitive purchasing procedures

In certain instances, there are national NHS contracts in force which mean that goods and services need to be sourced from a particular supplier. In other instances, procurement hubs have undertaken competitive tendering processes and due diligence for a generic range of goods and services. A list of approved suppliers under a framework has been developed by these organisations that the Trust can choose to use without the need for a further round of competitive process. The Trust's Procurement service provider can provide details of national contracts and approved supplier frameworks.

If, for any reason, the Trust opts not to go an approved framework, it will need to demonstrate that there has been fair competition. If, in the case of overwhelming reason, that there has not been a competitive process, a Waiver to Standing Financial Instructions must be completed and signed by the appropriate signatory before the contract is awarded. These waivers are reported to the Finance Performance Committee by the Director of Procurement.

Competitive procedures

Where a framework or national contract has not been used, the outline procedures below must be followed

<u>Contract or purchase value below £10,000 (exc.VAT)</u>

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.

<u>Contract or purchase between £10,001 and £50,000 (exc.VAT)</u>

At least three competitive written quotations will need to be obtained. As above, the selection may not be the cheapest, but there should be an evidenced evaluation of value for money to the Trust. The selection will need to be endorsed by the Director of Procurement as well as the authorising manager. A Quotations Register is maintained by Procurement.

Contract or purchase between £50,001 and the OJEU limit (currently £ 122,976) exc VAT

There will need to be a formal tendering exercise undertaken, managed by The Trust's Procurement service provider. Any waiver to this process will need to be endorsed by the Director of Procurement and approved by the Director of Finance (in his absence the Deputy Director of Finance).

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

Contract or purchase over OJEU limit (currently £122,976)

An OJEU-compliant tendering process will need to be undertaken. There can be no waiver to this process. For tender values over £1m, a Board member will need to give approval.

East and North Hertfordshire NHS
NHS Trust

Appendix 2

Detailed Limits of Delegation Policy

Introduction - Authorisation Limits

Where Directors, managers and other staff are authorising transactions on the Trust's behalf, the presumption is that they are doing so within the remit of their position as defined below, and within agreed budgets. Anyone operating outside these parameters will be considered as acting without due authority and may be subject to formal disciplinary procedures.

The processes below do not replace the Procurement process which requires obtaining competitive quotations and tenders, except in defined circumstances. Once the competitive process has been completed, any associated order is subject to the approval process below.

1. **Trust Service Level Agreements**

The Trust is commissioned to provide both clinical services and non-clinical services to other NHS and non-NHS organisations. It also receives services from other organisations. Provision or receipt of services over a period needs to be supported by a formal Service Level Agreement. New services should be subject to Board or Exec approval through the Business Case process, and the Service Level Agreements for the extension of existing agreements need to be reviewed by the Senior Contract Manager within Finance before approval.

The values below are based over the lifetime of the contract, as the responsible officer will be committing the Trust to the terms of that contract. Circumvention of the approval process, by splitting the contract into smaller units e.g. monthly payments, will be viewed as a disciplinary issue.

Type	Amount	Responsible Officer	Current Limit
Patient Activity Service Level Agreements with Commissioners	Over £50,000,001pa	Chief Executive and Director of Finance	To be nominated by the Chief Executive, limits Unchanged
	Between £10,000,001 and £50,000,000	Director of Finance	
	Up to £10,000,000pa	Chief Operating Officer and Assistant Director of Finance (Financial Planning)	
Agreements for the provision of non-patient services to other organisations *	Over £5,000,001pa	Chief Executive and Director of Finance	
	Between £1,000,001pa and £5,000,000	Director of Finance and appropriate Executive Director i.e Chief Operating Officer for Estates or Chief People Officer for HR SLAs	
	Between £10,001pa and £1,000,000	Deputy Director of Finance and Corporate Lead e.g. Estates, Finance, HR	
	Up to £10,000pa	Assistant or Associate Director of Finance and Corporate Lead e.g. Estates, Finance, HR	
Expenditure Service Level Agreements with other NHS bodies (Clinical)	Over £50,000,001pa	Chief Executive	
	Between £10,000,001 and £50,000,000	Director of Finance	
	Between £10,001pa and £1,000,000	Deputy Director of Finance and Divisional Director	
	Up to £10,000pa	Assistant or Associate Director of Finance and Divisional Director	
Expenditure Service Level Agreements with other NHS bodies (Non-Clinical)*	Over £5,000,000pa	Chief Executive and appropriate Executive Director i.e Chief Operating Officer for Estates or Chief People Officer for HR SLAs	
	Between	Director of Finance	

	£1,000,001pa and £5,000,000	and appropriate Executive Director i.e Chief Operating Officer for Estates or Chief People Officer for HR SLAs	
	Between £10,001pa and £1,000,000	Deputy Director of Finance and Corporate Lead e.g. Estates, Finance, HR	
	Up to £10,000pa	Assistant or Associate Director of Finance and Corporate Lead e.g. Estates, Finance, HR	

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

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

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

The amount of order value being considered for approval will be based on the agreed contractual value or, where the contract is over a period of years, the lifetime of the contract.

Please Note: The values below do not replace those for competitive quotations or waivers.

Type	Amount	Authorised Officer	Current Approver
Contracts for the provision of goods and services	Over £1,000,001	Subject to Board approval	Director of Procurement No change to approver limits
	Over £750,001 and up to £1,000,000	Chief Executive	
	Over £250,001 and up to £750,000	Director of Finance	
	Over £100,001 and up to £250,000	Other Executive Director	
	Over £50,001 and up to £100,000	Deputy Director of Finance	Unchanged
	Over £10,001and up to £50,000	Divisional Director/Divisional Chair/Assistant	Unchanged

		Director of Corporate area	
	Up to £10,000	General Manager, Divisional Nursing Services Manager, Head of Service	Unchanged
Pharmaceuticals	Any value	Director of Finance, Chief Operating Officer	Unchanged
	Up to £50,000	Head Pharmacist	
Catalogue or Non-Catalogue Orders, including Estates and Catering, once contracts have been agreed and non purchase order invoices	Over £750,001	Chief Executive or as delegated to Director of Finance	Unchanged
	Over £250,001 and up to £750,000	Director of Finance	
	Over £100,001 and up to £250,000	Other Executive Director	
	Over £50,001 and up to £100,000	Deputy Director of finance	Unchanged
	Over £10,001 and up to £50,000	Divisional Director/Assistant Director of Corporate area	Unchanged
	Over £5,000 and up to £10,000	General Manager, Divisional Nursing Service Manager, Head of Service	Unchanged
	Over £1,001 and up to £5,000	Departmental head / Budget Manager (Band 8 and above)	Unchanged
	Up to £1,000	Budget Manager (Band 7)	Unchanged
Pharmaceuticals	Any value	Director of Finance, Director of Operations	Unchanged
	Up to £50,000	Head Pharmacist	Unchanged

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

Type	Amount	Authorised Officer	Current Approver
All payment types below	Over £250,000	Director of Finance	Unchanged
Utilities (Phones, Electric, Gas, Water, Waste Collections)	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged
	Up to £50,000	Head of relevant area (IT, Estates)	Unchanged
Rates	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged

	Up to £50,000	Director of Estates	Unchanged
Lease car invoices	Over £5,001 and up to £250,000	Deputy Director of Finance	Unchanged
	Up to £5,000	Financial Controller	Unchanged
Computershare invoices (nursery vouchers)	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged
	Over £5,001 and Up to £50,000	Financial Controller	Unchanged
	Up to £5,000	Deputy Financial Controller	No limit

3. **Other Payments**

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

4. **Capital Expenditure**

The Capital Review Group will recommend the capital programme for each financial year to Exec, who will approve this programme. Any capital expenditure outside this programme will need to be presented in a formal bid to CRG to ensure that all Estates, Equipment and IT implications have been considered before it can be presented to the Exec meeting for approval. This includes all potential revenue schemes which have a capital implication.

Once the schemes have been approved, approval limits for orders placed will follow the revenue limits above outlined in Section2.

5. **Payroll and Other Contractual Payments connected with Employment**

Budget managers have delegated authority to approve pay, subject to the payments being within their funded establishment. However, any payments outside normal contractual terms and conditions, not reserved for approval by the Remuneration Committee, can only be made with the approval of the Director of Finance.

Type	Amount	Authorised Officer	Current Approver
Timesheets, recruitment forms, change forms	Any within budgetary limits confirmations	Line manager	Unchanged
Contractual payments on termination e.g. lieu of notice or redundancy	Over £10,001	Director of Finance	Unchanged
	Up to £10,000	Chief People Officer	Unchanged
Removal Expenses	Over £8,001	Director of Finance	Unchanged
	Up to £8,000	Chief People Officer or Director of Workforce	Unchanged

6. **Non-Contractual Payments connected with Employment**

Type	Amount	Authorised Officer	Current Approver
Extra contractual payments on termination (discretionary)	Any	None – these require approval by HM Treasury	Unchanged
Payments in connection with Employment Disputes e.g. Employment Tribunals	Over £50,001	Trust Board (or Chair and Chief Executive on behalf of the Board)	Unchanged
	Between £10,001 and £50,000	Chief People Officer and Chief Executive	Unchanged
	Up to £10,000	Chief People Officer or Director of Workforce	Unchanged

7. **Credit Note Requests**

The limits below relate to the raising of credit notes which, although valid, will impact on the amount of income reported. Where errors in raising invoices have been made, cancellation

of the incorrect invoice can be authorised by the Financial Controller/Deputy Financial Controller on the provision of evidence that the invoice will be re-raised correctly.

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

8. **Losses and Special Payments**

Category	Amount	Responsible Officer	Current approver
Bad debts Write-Off (must always have dual signatories)	Up to £1,000	Financial Controller plus One Assistant Director of Finance	Unchanged
	Over £1,001 and up to £5,000	Financial Controller or Assistant Director of Finance plus Deputy Director of Finance	
	Over £5,001 and up to £100,000	Financial Controller, Assistant or Deputy Director of Finance plus Director of Finance	
	Over £100,001 and up to £250,000	Chief Executive and Director of Finance	
	Over £250,001	Board	
Fraud/Theft	All values	To be reported to Audit and Risk Committee	Unchanged
Other Losses	To be approved through the Losses and Special Payments Committee in line with the Losses and Special Payments Policy. A summary is to be provided to Audit and Risk Committee twice yearly.		Unchanged

9. **Charitable Funds**

Before Charitable Funds income agreements (such as grant applications, acceptance of legacies and significant donations) and expenditure can be approved, it is expected that the Trust Business Case and governance processes have been adhered to. This will include confirmation of the support of divisions, identification of potential revenue issues for the Trust, compliance with Trust strategy and so on. In case of doubt, the Head of Engagement should be consulted.

Income and expenditure over the lifetime of the scheme or project should be considered

Category	Amount	Responsible Officer	Current approver
Expenditure on fund raising	Up to £2,500	Head of Charity (if within approved annual budget)	New limit
Other expenditure	Up to £500	Head of Charity + Divisional Director / Nominated substitute + Financial Controller / Executive Director	New limit
All income and other expenditure agreements	Up to £5,000	Charity Management Team (CMT)	Approved fund holder
	Over £5,001 and up to £500,000	Charitable Trustees Committee (CTC)	Unchanged
	Over £500,001	Trust Board	Unchanged

10. **ENH Pharma**

Approval limits will be set by the ENH Pharma Board, under its own Scheme of Delegation. However, the Trust expects that the governance processes will take into account the underlying principles contained within its Standing Orders and Standing Financial Instructions

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Public Board			**Agenda Item**	13
Report title	Summary Learning from Deaths Report			**Meeting Date**	3 May 2023
Presenter	Justin Daniels - Medical Director				
Author	Sarah El-Sharnoubi - Mortality Improvement Lead				
Responsible Director	Justin Daniels – Medical Director			**Approval Date**	08 March 2023
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

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

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

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

1. **Trust Strategic Objectives:**

Quality: Consistently deliver quality standards, targeting health inequalities and involving patients in their care

Thriving people: Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability

Seamless services: Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners

Continuous improvement: Continuously improve services by adopting good practice, maximising efficiency and productivity and exploiting transformation opportunities.

2. **Compliance with Learning from Deaths NQB Guidance**
3. **Potential impact in all five CQC domains**

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

Please refer to page 5 of the report

Report previously considered by & date(s):

Mortality Surveillance Committee – 08 March 2023
Quality & Safety Committee – 29 March 2023

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

To be trusted to provide consistently outstanding care and exemplary service

This report provides a summary of the information contained in the detailed Learning from Deaths report which has been considered both by the Mortality Surveillance Committee and the Quality and Safety Committee. This summary is provided to the public Board meeting in line with NQB Learning from Deaths national reporting requirements.

1. Headline mortality metrics

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

Table 1: Key mortality metrics

Metric	Headline detail
Crude mortality	Crude mortality is 1.14% for the 12-month period to January 2023 compared to 1.30% for the latest 3 years.
HSMR: (data period Dec21 – Nov22)	HSMR for the 12-month period is **94.36, 'Mid-range'.**
SHMI: (data period Oct21 – Sep22)	Headline SHMI for the 12-month period is **91.66, 'as expected' band 2.**
HSMR – Peer comparison	ENHT ranked 3rd (of 11) within the Model Hospital list* of peers.

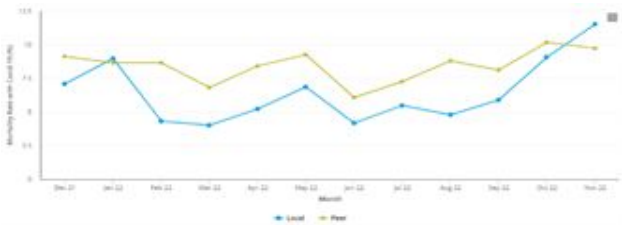
* We are comparing our performance against the peer group indicated for ENHT in the Model Hospital (updated in 2022), rather than the purely geographical regional group we used to use. Further detail is provided in 2.2.3.

2. COVID-19

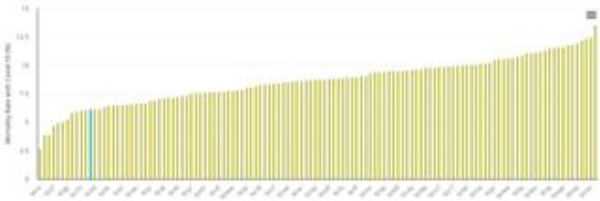
The following charts provided by CHKS show how the Trust's mortality rate for Covid compares with our national peers.

Fig 1: Covid-19 Peer Comparison: Dec21 to Nov22

Mortality Rate with Covid-19 (Peer: National)



Mortality Rate with Covid-19 National peer comparison



3. Mortality alerts

3.1 Rolling 12-month 3 standard deviation outlier CUSUM alerts

The latest release from CHKS showed two HSMR CUSUM red alerts which constituted a rolling 12-month 3 standard deviation outlier, for the year to November 2022. At February Mortality Surveillance Committee, a coding review of Leukemias was agreed. Due to the worsening position of AMI, it was agreed a formal review with presentation should be undertaken by Cardiology. This is now underway.

Table 2: HSMR CUSUM Alerts December 2021 to November 2022

	Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths
100 - Acute myocardial infarction	171.53	53	31	22
39 - Leukemias	227.41	18	8	10

Source: CHKS (CUSUM alerts coloured)

The CHKS report also indicated three SHMI CUSUM red alerts for the period to August 2022 which constituted rolling 12-month 3 standard deviation outliers, as detailed in the table below. These were discussed at February Mortality Surveillance Committee. A completed coding review of skin and subcutaneous tissue infections had shown few coding errors, but a significant number of pressure

ulcers seen on admission. The data is being shared appropriately. Coding reviews of skin disorders and abdominal hernia remain in progress.

Table 3: SHMI Outlier Alerts September 2021 to August 2022

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths
108 - 198, 199, 200: Skin disorders	231.89	23	10	13
107 - 197: Skin and subcutaneous tissue infections	185.80	27	15	12
87 - 143: Abdominal hernia	240.32	12	5	7

3.2 External alerts

National Hip Fracture Database (NHFD) mortality alert (August 2019)

As previously reported, in June 2021 we received notification from the NHFD that in the forthcoming annual report we would be showing as a 3 standard deviation outlier.

At its worst point, for the period to January 2021, 30-day mortality stood at 13.5%, significantly above the national average of 8.7%. The latest data to July 2022 shows a significant improvement to 6.7%, compared to a national figure of 5.0%.

At February Mortality Surveillance Committee, it was agreed that the current work had progressed as far as it could, with the outstanding action regarding theatre capacity being integrated into a wider workstream. The Mortality Improvement Lead agreed to work with the Neck of Femur (NOF) Lead to update the original interim report to final.

4. Focus areas for improvement/monitoring

Table 4: Focus Areas for Improvement

Diagnosis group	Summary update
Cardiology diagnoses	Following an initial six-month joint Cardiology-Coding initiative to review MI, the work to monitor the cardiology basket of diagnoses has been slow to get established. As a result of the continuing deterioration in the Trust's HSMR for acute myocardial infarction, in February the Mortality Surveillance Committee requested the service to undertake an immediate review of the situation and report back to the Committee, if feasible in March. Further action will be determined on the basis of the review outcomes.
Sepsis	HSMR performance relative to national peer remains well placed. There has been some improvement regarding achievement of sepsis targets with the exception of ED Sepsis 6 Bundle compliance.
Stroke	Latest SSNAP rating remains D. April to July 2022 has seen HSMR steadily increasing. Following the national set up of Integrated Stroke Delivery Networks (ISDNs), collaborative work via the East of England South network continues.
Emergency Laparotomy	Focussed improvement work remains on-going. This has included the setting up of a working group to support the service. A NELA data coordinator is now in post and focussed on clearing the backlog of cases. It is recognised that correct case ascertain is extremely important. In this regard strengthening the multi-disciplinary approach, especially for high-risk patients will remain a focus for the improvement work. Ongoing challenges include the current lack of a dedicated Emergency Theatre for general surgery, the lack of a NELA radiology lead and the ongoing delay to the re-establishment of the Surgical Assessment Unit.

5. Learning from deaths data

5.1 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below for Q3 2022-23.

Table 5: Q3 2022-23: Learning from deaths data

	Oct-22	Nov-22	Dec-22
Total in-patient deaths	110	105	140
Deaths with SJR completed to date (at 08.02.23)	48	35	17
SJRs resulting in Datix incident report (by month of death)	11	8	4
Concluded ACONs (2021-22 deaths): possibly avoidable (≥50%) due to problem in care (by month of conclusion)	0	0	0
Learning disability deaths	2	1	2
Mental illness deaths	1	2	1
Stillbirths	2	1	2
Child deaths (including neonats/CED)	0	0	0
Maternity deaths	0	0	1
SIs declared regarding deceased patient	3	4	3
SIs approved regarding deceased patient	0	2	1
Complaints regarding deceased patient	2	1	0
Requests for a Report to the Coroner	11	11	6
Regulation 28 (Prevention of Future Deaths)	0	0	0

5.2 Learning from deaths dashboard and outcomes summary

The National Quality Board provided a suggested dashboard for the reporting of core mandated information. This dashboard has previously been provided in this report. However, the current transition from our old in-house mortality review tool to using the SJR*Plus* tool and approach, part way through the 2022-23 reporting year presents a reporting challenge, as the data aligns differently. In the short term, while the transition is made, the dashboard will not be used. It is proposed that from Q1 2023-24 either it, or an alternative contextual dashboard created by the NHSE Making Data Counts team, will be reintroduced.

5.2.1 Concluded ACONs

In the meantime, until all ACONs raised up to 30 June 2022 are completed, both ACONs – with their outcomes, and new patient safety escalations with theirs, will be reported. Every effort is being made to close legacy ACONs as quickly as possible. In the longer term, the new SJR process will make reporting easier, as the preventability of death is indicated by the reviewer at the point of the initial review, not on completion of the ACON process, which will reduce the current time lag.

It should be noted that for cases where Areas of Concern (ACONs) have been raised, the current lapse in time between the death and completion of the review process means that the avoidability of death score may not be decided in the same review year. Therefore, for the sake of transparency and robust governance this report details ACONs relating to all deaths which have been concluded during the quarter in question where the Mortality Surveillance Committee agreed an avoidability of death score of 3 or less (irrespective of the year in which the death occurred). Table 6 below details relevant cases concluded in Q3. All six of these cases had been rigorously investigated as serious incidents.

It should be noted that the reported ACONs concluded in this quarter included a significant backlog of historic serious incidents, which had been awaiting final sign-off. This is reflected in the unusually high number of possibly avoidable deaths.

Table 6: Q3 2022-23 Concluded ACONs: Avoidability Score ≤3

ID	Year of death	Serious Incident	Avoidability score	Avoidability definition
-	-	-	1	Definitely avoidable
-	-	-	2	Strong evidence of avoidability
509	2020/21	Yes	3	Possibly avoidable: more than 50-50
551	2020/21	Yes		
561	2020/21	Yes		
605	2020/21	Yes		
681	2020/21	Yes		
697	2021/22	Yes		

5.2.2 SJR patient safety incident escalations since 1 July 2022

Since the start of Q2 mortality reviews are now undertaken using the SJR*Plus* format and methodology. For deaths in Q2/Q3 which have been subject to an SJR, 48 cases have been escalated as potential patient safety incidents. When we adopted the SJR format and revisited our internal quality and governance processes, it was agreed with our Patient Safety team, that where a reviewer indicated there was any evidence of preventability, the case should be raised as a patient safety incident, ensuring thorough review and discussion of the case at Specialty/Divisional level. As a result, new patient safety escalations do not directly correlate to prior cases raised as ACONs. They will include cases involving a lower level of concern, but which still provide valuable opportunities to learn.

Table 7: Q2/Q3 Patient Safety Incidents reported following SJR

Escalations for deaths in month	Jul	Aug	Sep	Oct	Nov	Dec	Total
Patient Safety incident scalations from SJRs	11	9	5	11	8	4	48

Learning from concluded patient safety investigations will be collated and added to themes and trends identified in SJRs to inform future quality and improvement work.

6. Learning and themes from concluded mortality reviews

Historically, throughout the year emerging themes have been collated and shared across the Trust via governance and performance sessions and specialist working groups. The information has also been used to inform broad quality improvement initiatives. With the advent of a new approach to mortality review, the ways in which learning is shared and the methods for assessing its impact are being revisited.

7. Current risks

Table 8 below summarises key risks identified:

Table 8: Current risks

Risks	Red/amber rating
Cardiology: recurrent HSMR and SHMI alerts (especially AMI)	
Medical Examiner Integration & Community expansion	
Mortality review reform: Using the new review tool for reporting & learning	
Transition from Datix to ENHance: using the new system for escalation, reporting and learning	

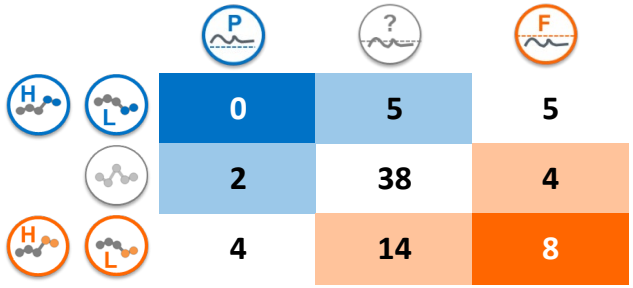
3.0 Options/recommendations

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

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 12 | 2022-23

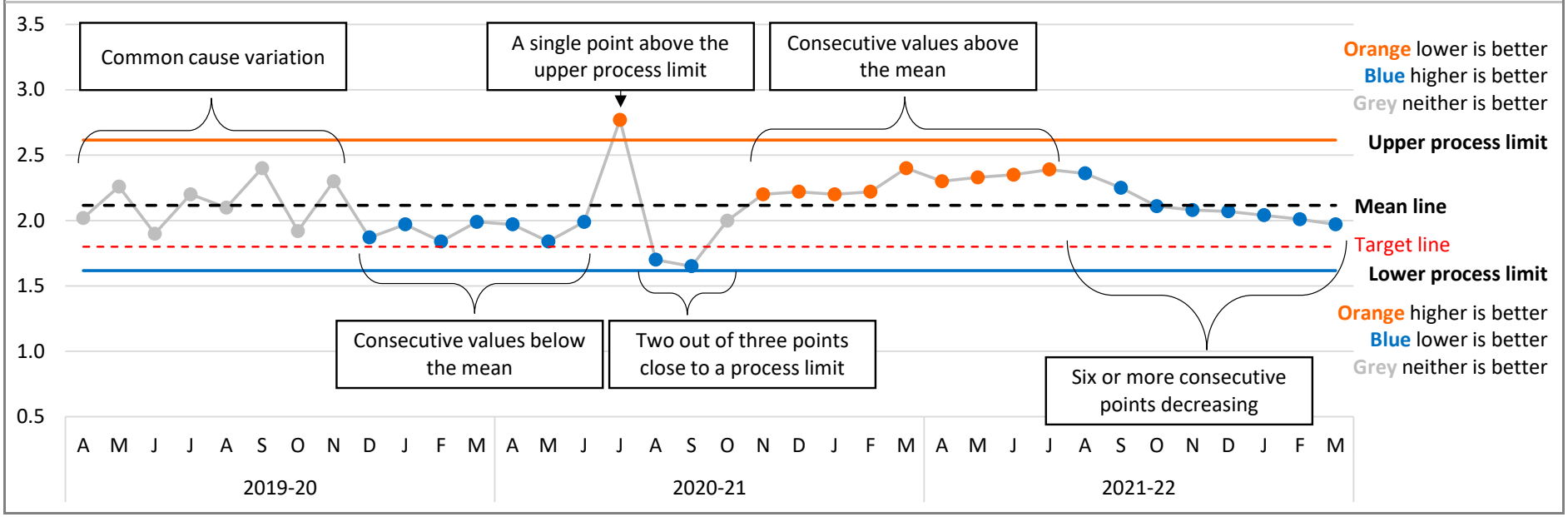


Data correct as at 21/04/2023

Integrated Performance Report

East and North Hertfordshire NHS Trust

How to interpret a Statistical Process Control (SPC) Chart



Variation

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

Assurance

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

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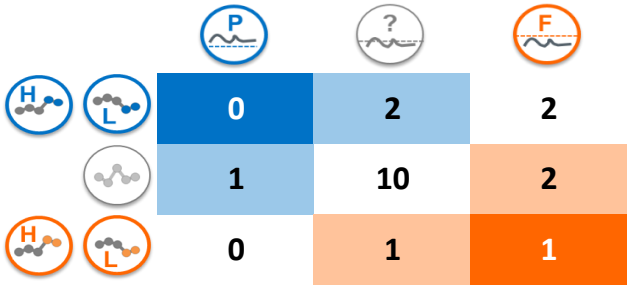
Safe Services

Month 12 | 2022-23



Safe Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	Mar-23	n/a	1,297			Common cause variation No target
	Serious incidents in-month	Mar-23	0	3		?	Common cause variation Metric will inconsistently pass and fail the target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Mar-23	0	0	L	?	Seven consecutive points below the mean Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Mar-23	0	7		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Mar-23	0	3		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Mar-23	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Mar-23	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Mar-23	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Mar-23	0	0	L	?	Seven consecutive points below the mean Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Mar-23	80%	91.6%		P	Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	Mar-23	n/a	76.3%			Common cause variation No target
	Staff shortage incidents	Mar-23	n/a	32	H		Seven consecutive points above the mean No target

Month 12 | 2022-23

Safe Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	Mar-23	n/a	0.78			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Mar-23	n/a	0.65			Common cause variation No target
Deteriorating Patients	Reliability of observations (4-hour)	Mar-23	n/a	71.6%			Common cause variation No target
	Reliability of observations (1-hour)	Mar-23	50%	38.3%	L	F	15 consecutive points below the mean Metric will consistently fail the target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Mar-23	95%	100.0%	H	?	Seven consecutive points above the mean Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Mar-23	95%	69.2%	H	F	10 consecutive points above the mean Metric will consistently fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Mar-23	95%	92.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Mar-23	95%	64.3%	H	F	18 consecutive points above the mean Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Mar-23	85%	81.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	VTE risk assessment for stage 2, 3 and / or 4	Mar-23	85%	59.4%		F	Common cause variation Metric will consistently fail the target
	Correct low molecular weight heparin prescribed and documented administration	Mar-23	85%	89.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	TED stockings correctly prescribed and documentation of fitted	Mar-23	85%	55.3%	L	?	8 consecutive points below the mean Metric will inconsistently pass and fail the target

Month 12 | 2022-23

Safe Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
HATs	Number of HAT RCAs in progress	Mar-23	n/a	84	H		One point above the upper process limit No target
	Number of HAT RCAs completed	Mar-23	n/a	12			Common cause variation No target
	HATs confirmed potentially preventable	Mar-23	n/a	3			Common cause variation No target
PU	Pressure ulcers All category ≥2	Mar-23	0	24		F	Common cause variation Metric will consistently fail the target
Patient Falls	Rate of patient falls per 1,000 overnight stays	Mar-23	n/a	3.9			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Mar-23	n/a	3.7%			Common cause variation No target
Other	National Patient Safety Alerts not completed by deadline	Jan-23	0	0			Metric unsuitable for SPC analysis
	Potential under-reporting of patient safety incidents	Feb-23	6.0%	5.8%			Metric unsuitable for SPC analysis

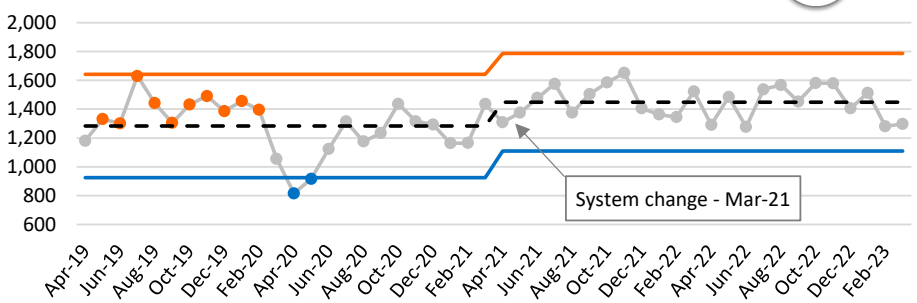
Month 12 | 2022-23

Safe Services

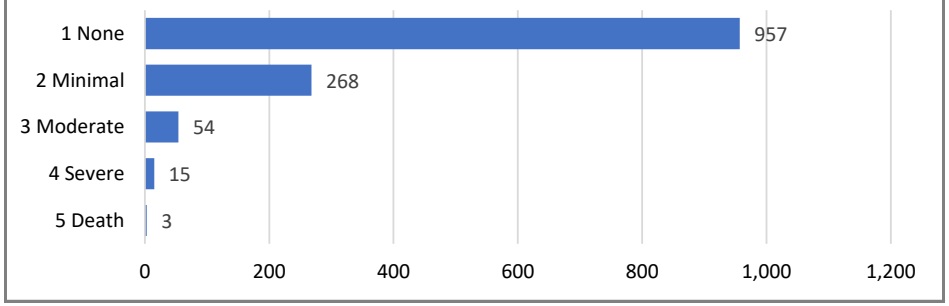
Patient Safety Incidents

East and North Hertfordshire NHS Trust

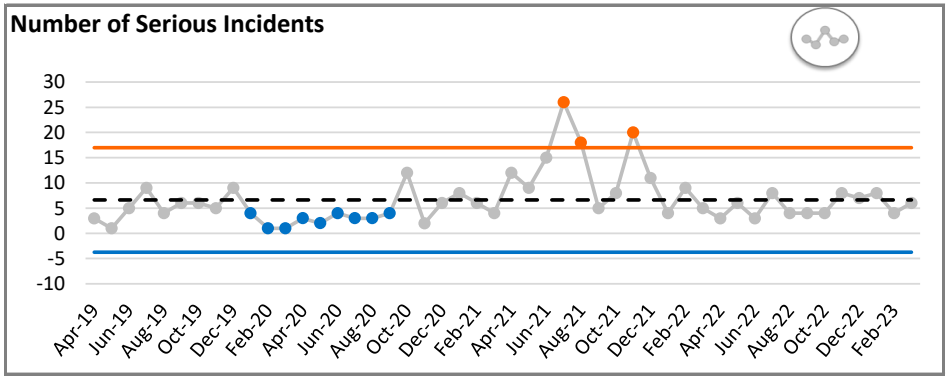
Total incidents reported



Number of incidents by level of harm - Mar-23



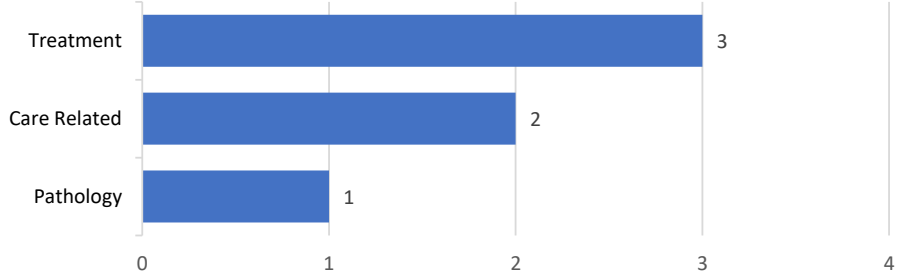
Number of Serious Incidents



Key Issues and Executive Response

- Common cause variation is evident in the number of incidents reported, with an average of 1448 incidents reported per month.
- Approximately 97% of incidents reported resulted in no or low harm, which is in-line with previous months.
- The trust incident reporting system 'ENHance' continues to undergo design and reporting phases to improve trust operational requirements across Divisions.
- Common cause variation in the number of SIs declared, with an average of 6 per month.
- 3 new SIs declared in March relating to patients delayed follow up / lost to follow up.
- Ongoing focus on ensuring momentum maintained with progressing SI reports and associated learning promptly.
- Planning has started in response to deliver the national patient safety incident review framework (PSIRF).

Serious Incidents Themes - Mar-23



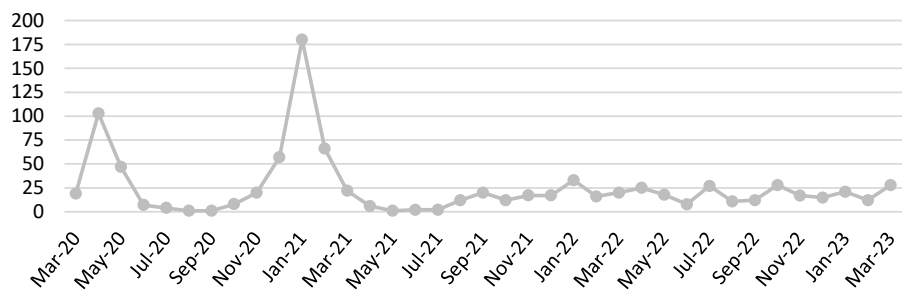
Month 12 | 2022-23

Safe Services

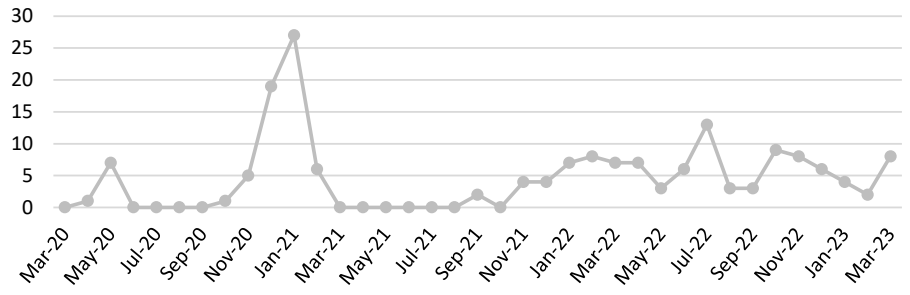
COVID-19

East and North Hertfordshire NHS Trust

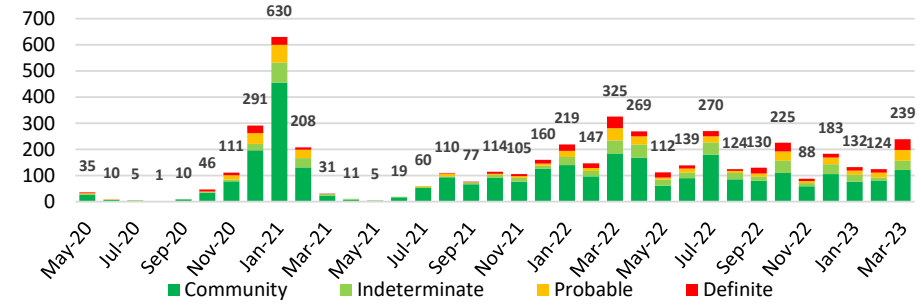
Number of deaths from COVID-19



Number of deaths from hospital-acquired COVID-19



COVID-19 cases by category



Key Issues and Executive Response

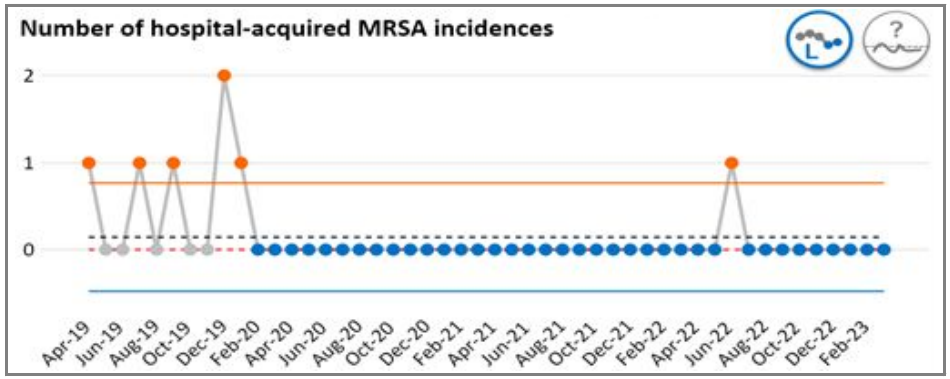
- A slight increase in COVID cases were seen in March, the total number was 239. Of these cases 83 were contributed to probable or definite hospital-onset COVID.
- Sadly 28 patients died with a diagnosis of COVID in March, and 8 of these cases were related to hospital-onset COVID.
- Structured reviews are undertaken locally to capture learning where a hospital acquired infection has been identified. Where any potential harmful impacts are identified cases shall be represented to serious incident review panel.
- Intermittent bay closures have occurred in response to infection and prevention control risks in March. Mobile Redirooms are in use to support patient isolation without having to move patient form ward to ward.

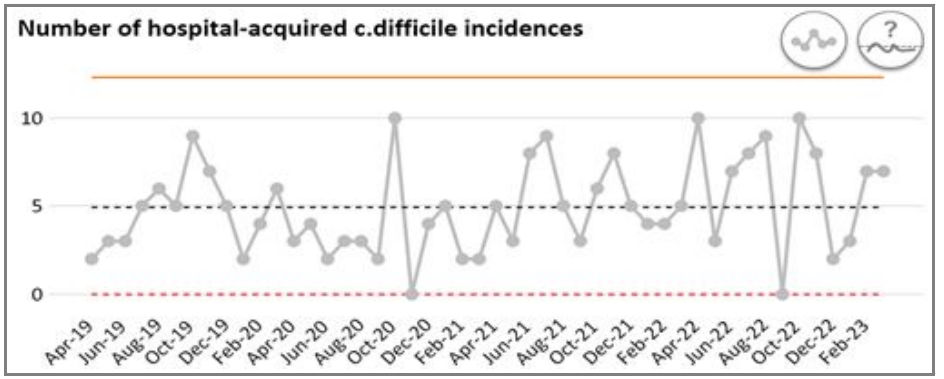
Month 12 | 2022-23

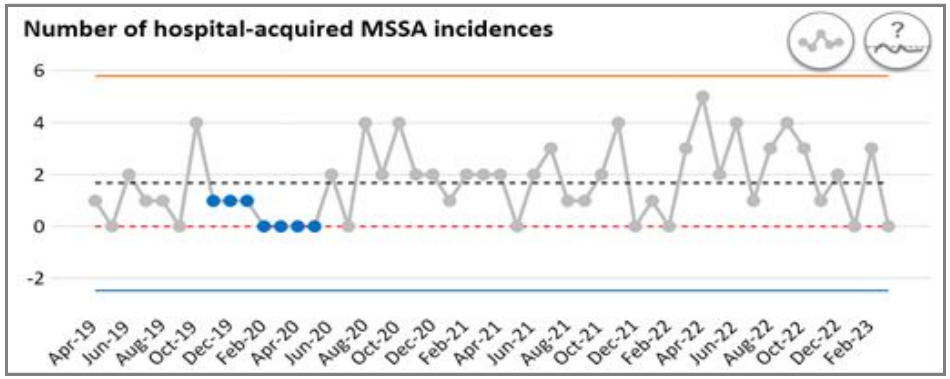
Safe Services

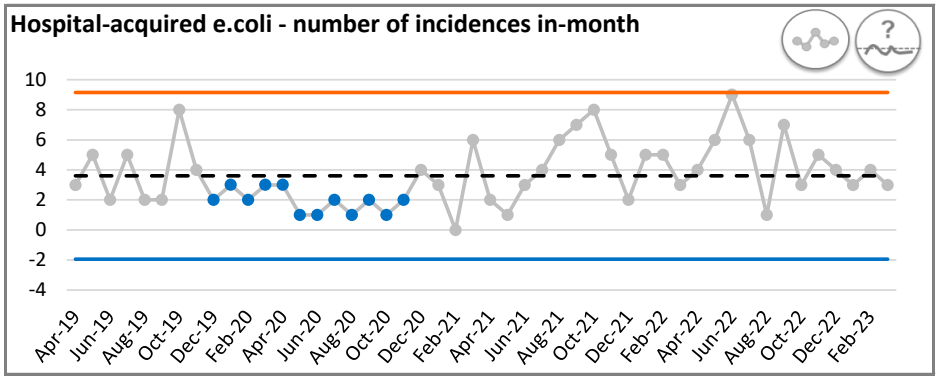
Infection Prevention and Control

East and North Hertfordshire NHS Trust









- The C. difficile year to date (YTD) total is 73 against the threshold of 59. There were three (3) Hospital Onset Healthcare Associated (HOHA) cases, and four (4) Community Onset Healthcare Associated (COHA) cases in March 2023. A total of 29 cases have been identified as appealable: nine (9) cases have been heard thus far, of which one (1) is to be allocated to another Trust, six (6) have been successfully appealed and two (2) are to be resubmitted. The 73 cases are now reduced to 67 with an expected further decrease after the 20 appeal cases are heard in April 23.

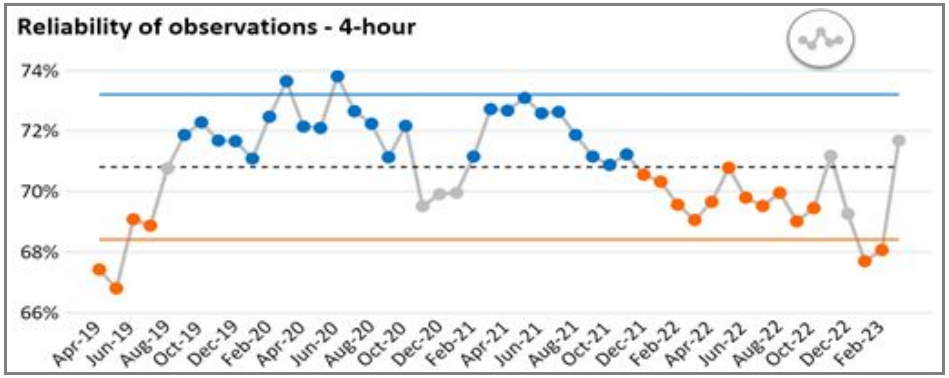
- The MRSA YTD total is one (1), which is above the threshold of zero (0). There are zero (0) cases in March 2023.
- The MSSA YTD total is 28 (no threshold set). There are zero (0) cases in Mar '23.
- The E.coli YTD total is 55, which is above the threshold of 46. There were two (2) COHA, and one (1) HOHA in March 2023.
- Improvement work in aseptic technique and catheter care is being carried out locally and with the ICS. This will improve blood stream infections.

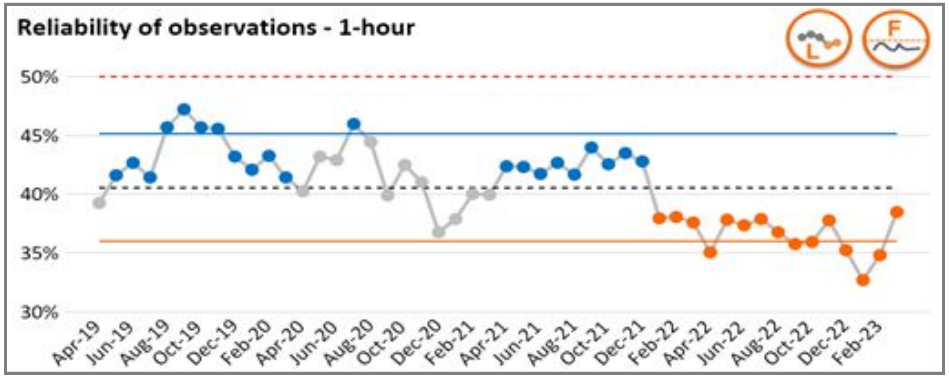
Month 12 | 2022-23

Safe Services

Deteriorating Patients

East and North Hertfordshire NHS Trust





Key Issues and Executive Response

- There has been weekly performance improvement meeting to focus barriers and themes around 4 hourly/hourly observations and data publication from Eobs system.
- Learning in March has highlighted new risks associated with the accuracy of some data sets i.e. the population measured with data sets are inaccurate, changes to improve this are being scoped by the trust BI team and clinical leads.
- NEWS2 e-learning now role essential to not only nurses and non-registered nursing staff but to pharmacy staff and AHPs.
- Drs escalation work being piloted within the Renal wards to improve reliability and response to escalations to our medical staff.

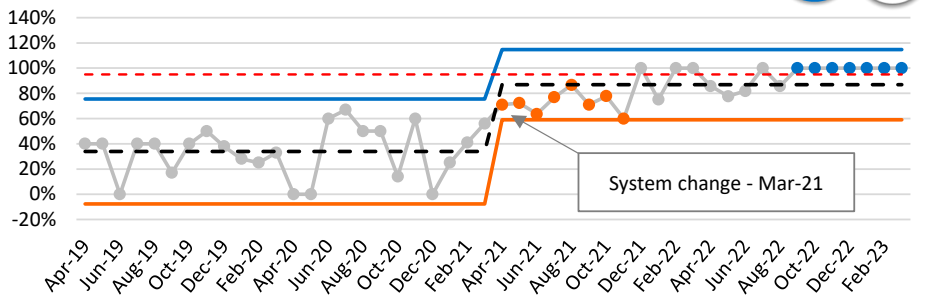
Month 12 | 2022-23

Safe Services

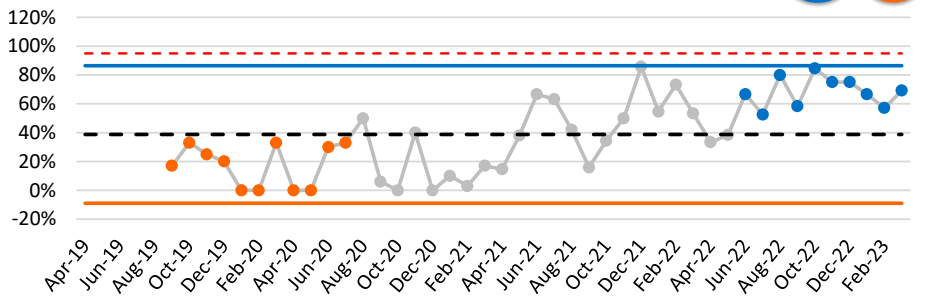
Sepsis Screening and Management | Inpatients

East and North Hertfordshire NHS Trust

Inpatients receiving IVABs within 1-hour of red flag



Inpatients Sepsis Six bundle compliance



Themes

Sepsis IP	2022-23											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	55%	93%	82%	89%	92%	86%	82%	83%	86%	88%	100%	100%
IV antibiotics	86%	83%	82%	92%	86%	92%	100%	100%	100%	100%	100%	100%
IV fluids	50%	90%	86%	50%	100%	75%	86%	100%	100%	100%	100%	67%
Lactate	50%	86%	76%	67%	89%	70%	83%	88%	80%	63%	62%	80%
Urine measure	42%	60%	74%	73%	87%	76%	100%	88%	88%	75%	86%	86%

Key Issues and Executive Response

Themes

- Blood culture collection in the IP setting is at 96%, and remains above the trust target of 95% for the second month in a row.
- Urine output monitoring compliance in the IP areas has dipped to 79% and remains a key area of focus of improvement
- IV antibiotic administration remains at 100% compliance again whilst IV fluid administration has dropped slightly to 94% it is still greatly improved from previous months.
- Lactate measurement saw a slight increase in compliance to 65% from 62% the previous month. However it remains something we need to continue to support within the IP setting.
- The overall sepsis 6 compliance for inpatient areas has trended upwards to 71% in March. Yet, the downfall can be again attributed to low compliance in Urine output and lactate measurement.

Response

- The Sepsis Team continues to support IP areas by being clinically visible when Red Flag Sepsis triggers have been identified/ when called by wards, despite short staffing levels affecting the amount of clinical time.
- Sepsis E-Learning is live on the ENH Academy, requiring all registered clinical staff in the trust (Nurses, RNAs etc.) to complete. We are collating data regarding ward compliance to highlight areas that need additional support to completing this training.
- We have rolled out a new Sepsis E-Learning targeted specifically at CSWs, HCSs and EMTs and is live on ENH Academy.
- The Sepsis team are working to digitalise the sepsis proforma which will greatly benefit the IP setting allowing for clear documenting of the sepsis 6.
- The team will start taking part in trust nurse inductions regularly alongside the CSW inductions and BEACH sessions that are already underway.

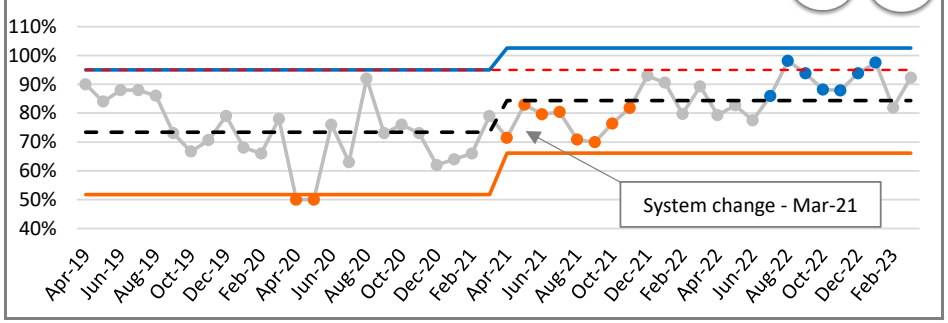
Month 12 | 2022-23

Safe Services

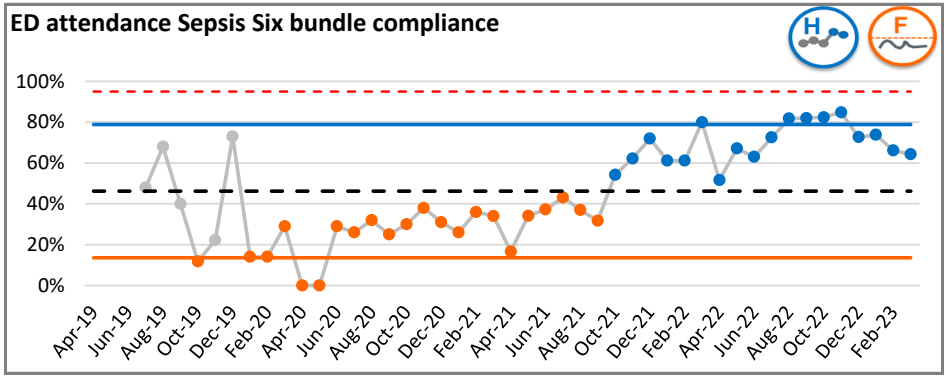
Sepsis Screening and Management | Emergency Department

East and North Hertfordshire NHS Trust

ED attendances receiving IVABs within 1-hour of red flag



ED attendance Sepsis Six bundle compliance



Themes

Sepsis ED	2022-23											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	100%
Blood cultures	86%	89%	91%	87%	98%	93%	88%	94%	93%	90%	90%	93%
IV antibiotics	79%	83%	76%	86%	98%	92%	88%	88%	94%	98%	82%	93%
IV fluids	95%	86%	80%	93%	96%	96%	93%	90%	92%	97%	85%	100%
Lactate	87%	97%	95%	67%	98%	97%	100%	97%	100%	100%	95%	100%
Urine measure	69%	79%	77%	84%	81%	84%	88%	94%	78%	81%	74%	79%

Key Issues and Executive Response

Themes

- Fluid balance and urine measurement has improved in March to 79%, however this still remains a priority for improvement through locally led changes.
- Overall Sepsis 6 compliance in ED sits at 69% for March; a large downward trend in lactate compliance as well as consistently low compliance in urine measurement can be attributed to this.

Response

- ENH academy training for Sepsis remains live and we continue to monitor compliance with high staff turnover in the ED.
- The Sepsis team has been continuously supporting ED by being clinically visible when a Septic patient is identified, providing support and bedside education to newer/junior staff.
- The team is continuing to trial the use of Digital Fluid Balance Chart in ED (particularly in Resus patients first) and continues to educate on the importance of accurate fluid balance monitoring.
- The Sepsis team is working to digitalise the sepsis proforma making it more accessible to staff across the trust and in ED.
- The sepsis team are looking to repeat it's AKI/Sepsis simulations in the coming months to help support with the care of septic patients.

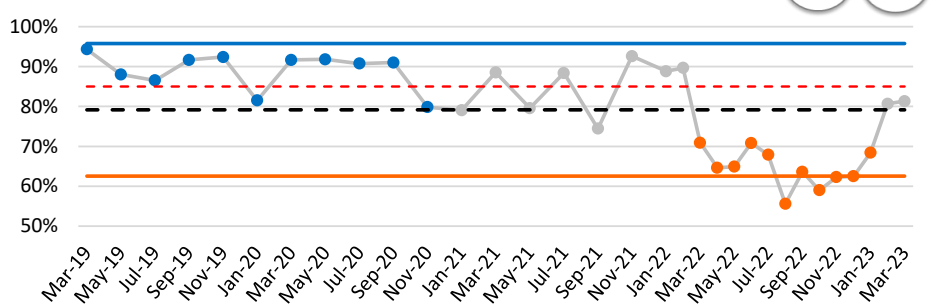
Month 12 | 2022-23

Safe Services

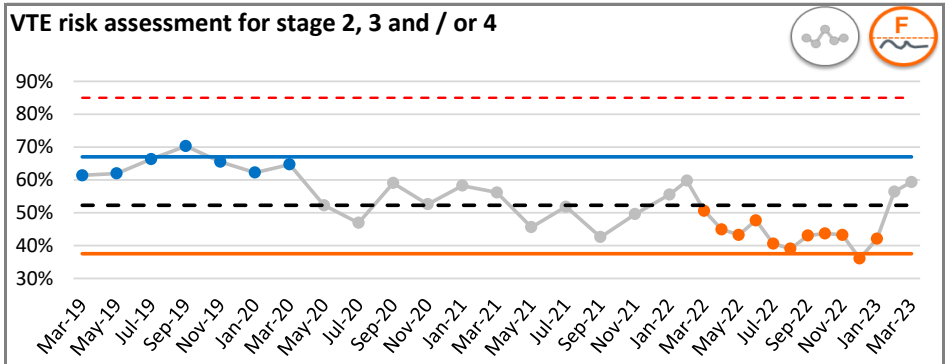
VTE Risk Assessment

East and North Hertfordshire NHS Trust

VTE risk assessment stage 1 completed



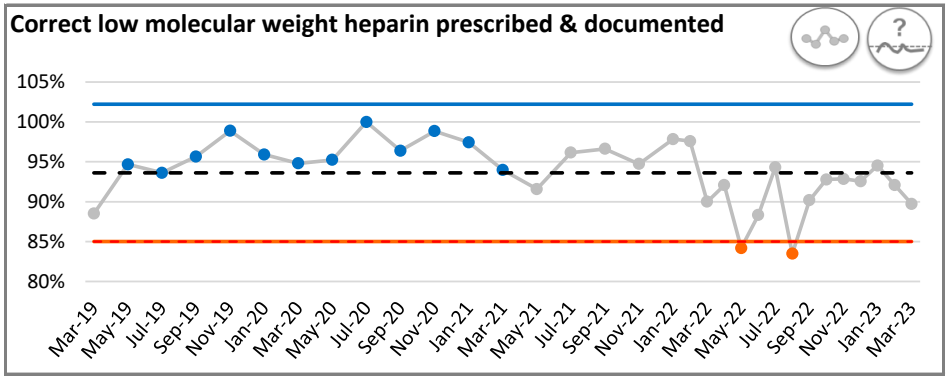
VTE risk assessment for stage 2, 3 and / or 4



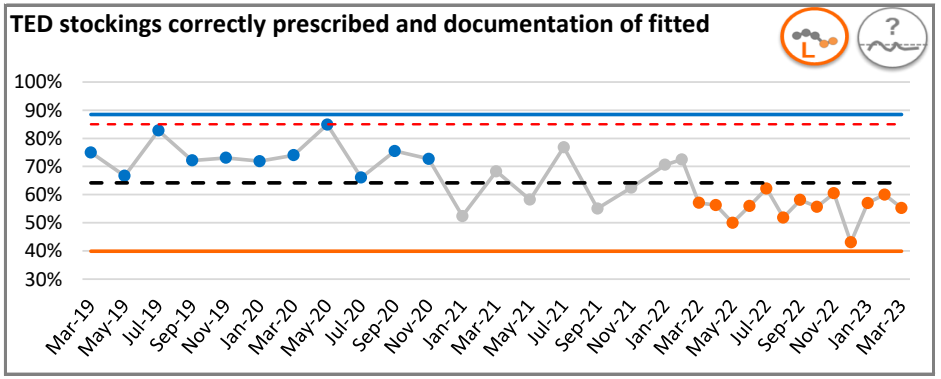
Key Issues and Executive Response

- The trust changed how VTE risk assessment was documented in April 2022 through introducing ePMA/Lorenzo, which provided some reliability risks.
- VTE risk assessment then changed from ePMA/Lorenzo into Nerve Centre from 30th January 2023.
- This change has enabled visibility in digital screens ('patient safety at a glance') that supports real time review of patients requiring assessments to be completed. Further changes are required to accurately report patient moves between clinical areas and to acknowledge separate VTE 1 and 2 risk assessments.
- Oversight of daily/weekly/monthly data is in place to ensure ongoing drive of spot checks in March.
- Several clinical areas have QI projects in progress and show local improvements, through reviewing local data and understanding gaps.
- Implemented semi-regular VTE update/HAT case presentation sessions with FY1/FY2 (on average 4 per year). To continue in 2023.

Correct low molecular weight heparin prescribed & documented



TED stockings correctly prescribed and documentation of fitted



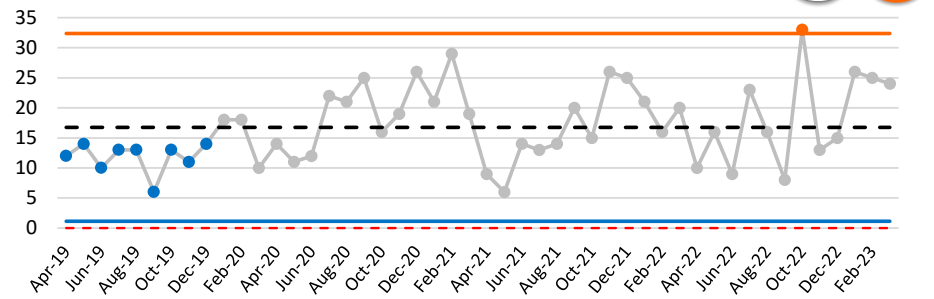
Month 12 | 2022-23

Safe Services

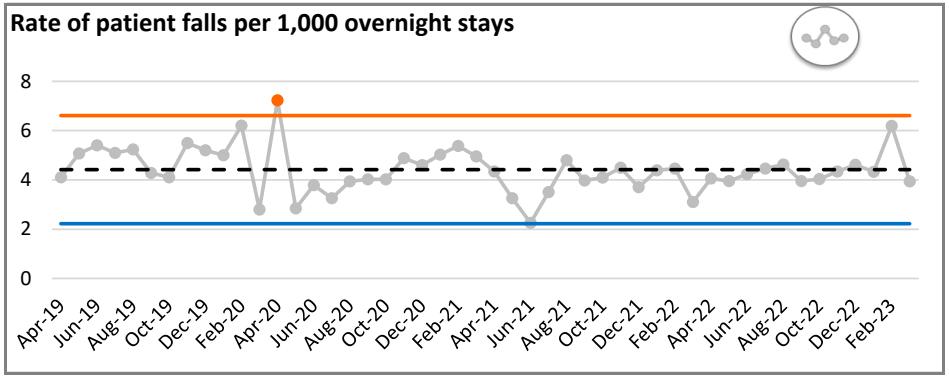
Pressure Ulcers | Patient Falls

East and North Hertfordshire NHS Trust

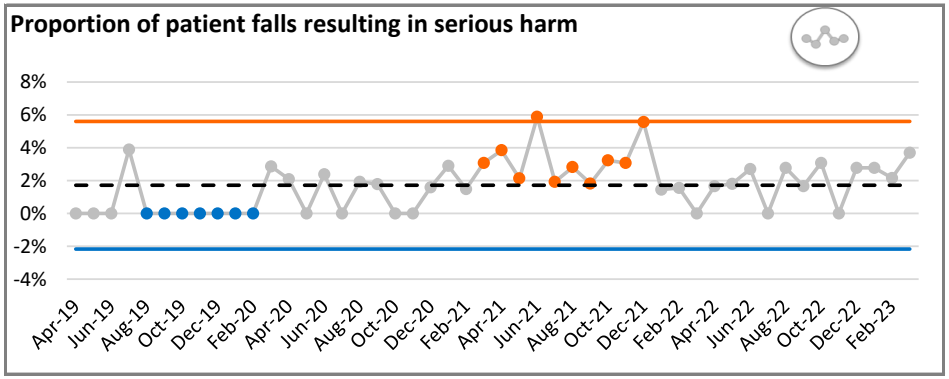
Number of hospital-acquired pressure ulcers



Rate of patient falls per 1,000 overnight stays



Proportion of patient falls resulting in serious harm



Key Issues and Executive Response

Pressure ulcers

- Taking of medical photos from NC is a new feature, coming soon. This will hopefully increase TVN validation of PU.
- Ward 6B will be getting PU Bitesize training on a regular basis following dates arranged convenient to them.
- CSW are getting extra Trust Induction session on prevention of pressure ulcers.
- Ward staff have started booking in for the face - face Tissue Viability study days, starting June this year.
- Completion of digital waterlow assessment within 6 hours of admission is an improvement priority. Supporting 23/24 CQUIN .
- TVN-related assessments and care plans now live in Nerve Centre and across all adult inpatient areas. This, alongside increased use of WABA app allows for TVN to have greater oversight of skin issues within ward areas.
- TVN auditing staff knowledge of pressure ulcer prevention, focusing on wards with highest number and then expanding to other areas. Work ongoing to address gaps in knowledge.'
- Tissue viability policy reviewed will be published in April 2023.

Patient falls

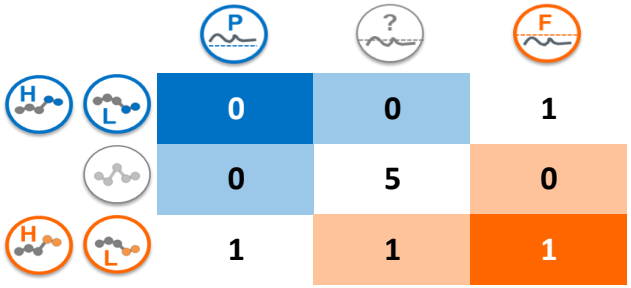
- Inpatient falls data continues to show common cause variation, with an average of 4 per month per 1000 bed days.
- 3 falls with harm were recorded for the month of March. SIs were clustered to generate trust-wide learning.
- Local safety improvements have been targeted in ED, in repose to a cluster of incidents.
- Learnings from national event shared trust-wide and presented on Harm Free care meeting.
- Falls policy reviewed and with stakeholders for further comments, this will be published in April 2023.

Month 12 | 2022-23

NHS
East and North Hertfordshire
NHS Trust

Caring Services

Month 12 | 2022-23



Caring Services

Summary

East and North Hertfordshire NHS Trust

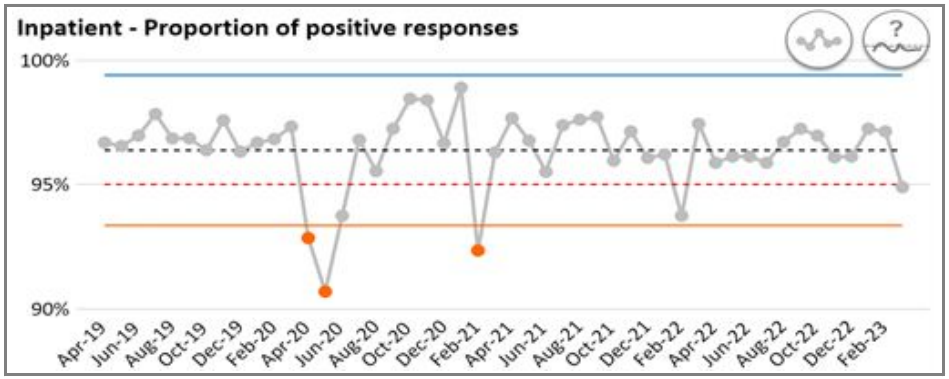
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Friends and Family Test	Inpatients positive feedback	Mar-23	95%	94.9%		?	Common cause variation Metric will inconsistently pass and fail the target
	A&E positive feedback	Mar-23	90%	89.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Mar-23	93%	94.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Birth positive feedback	Mar-23	93%	100.0%	H	F	One point above the upper process limit Metric will consistently fail the target
	Maternity Postnatal positive feedback	Mar-23	93%	100.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Community positive feedback	Mar-23	93%	0.0%	L	F	Three points below the lower process limit Metric will consistently fail the target
	Outpatients FFT positive feedback	Mar-23	95.0%	94.7%		?	Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Mar-23	n/a	309		-	Common cause variation No target
Complaints	Number of written complaints received in-month	Mar-23	n/a	73		-	Common cause variation No target
	Number of complaints closed in-month	Mar-23	n/a	93		-	Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	Mar-23	75%	78.9%	L	P	Two points below the lower process limit Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	Mar-23	80%	41.4%	L	?	Three points below the lower process limit Metric will inconsistently pass and fail the target

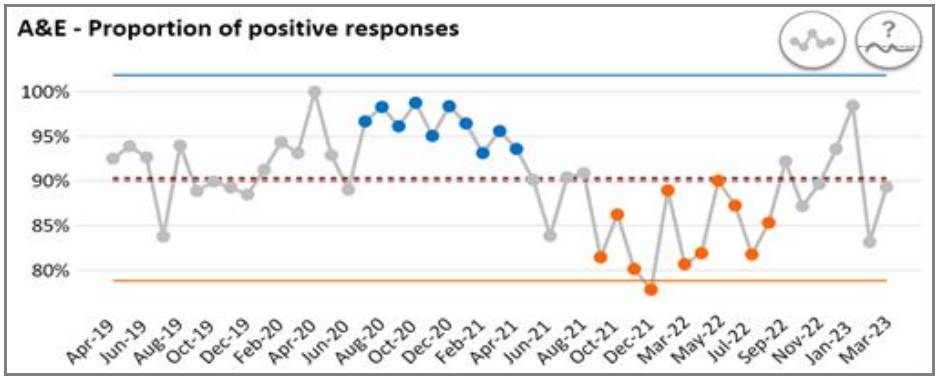
Month 12 | 2022-23

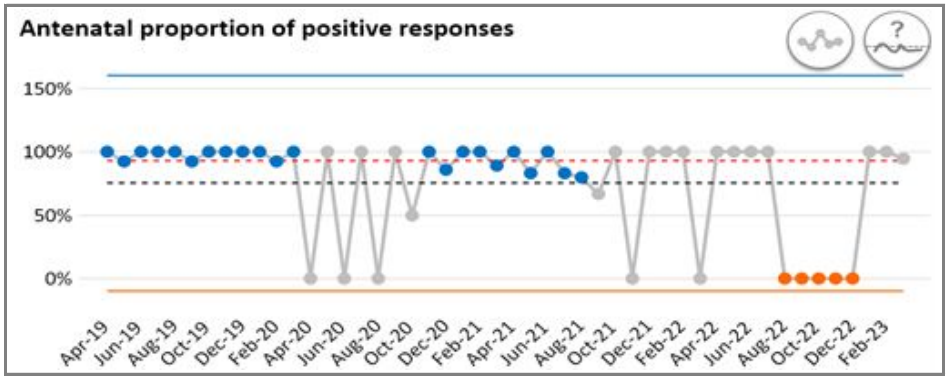
Caring Services

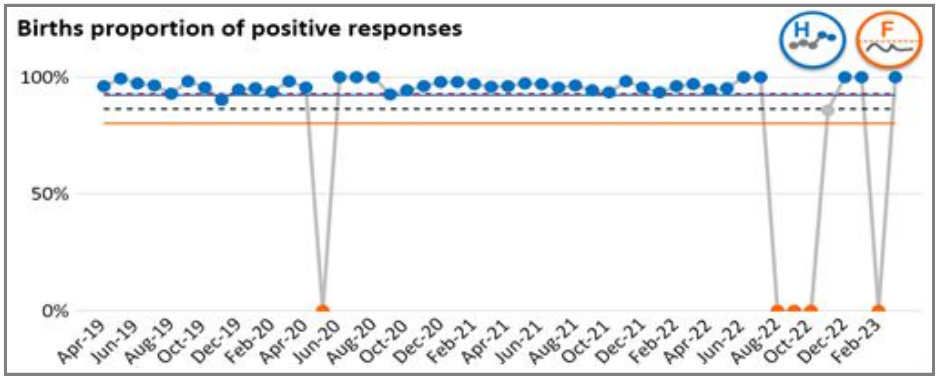
Friends and Family Test

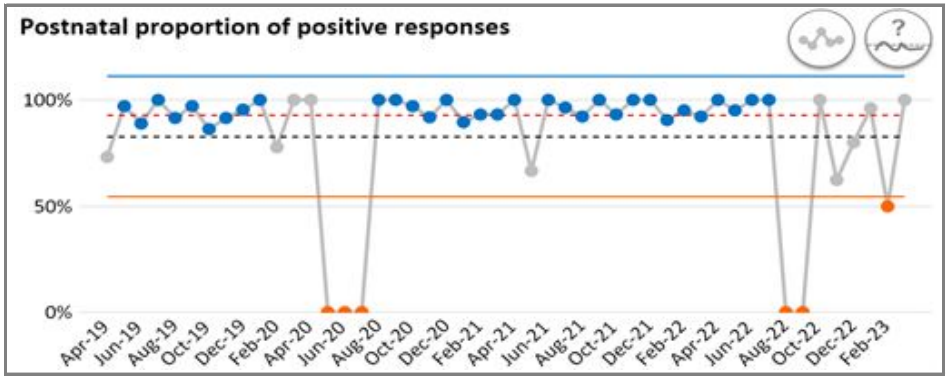
East and North Hertfordshire NHS Trust

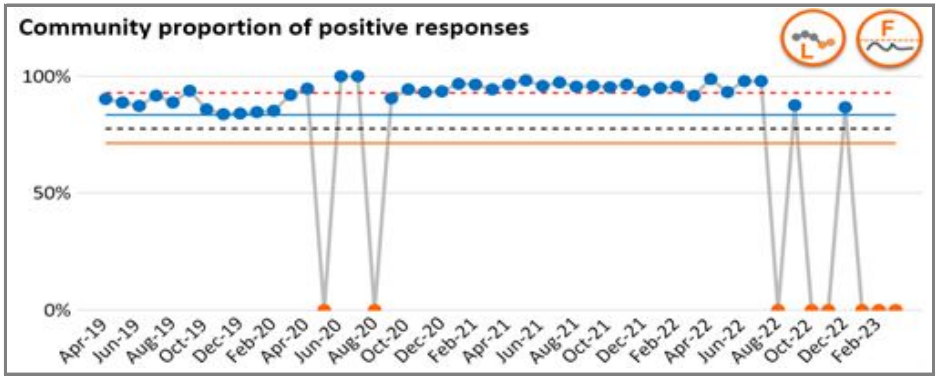










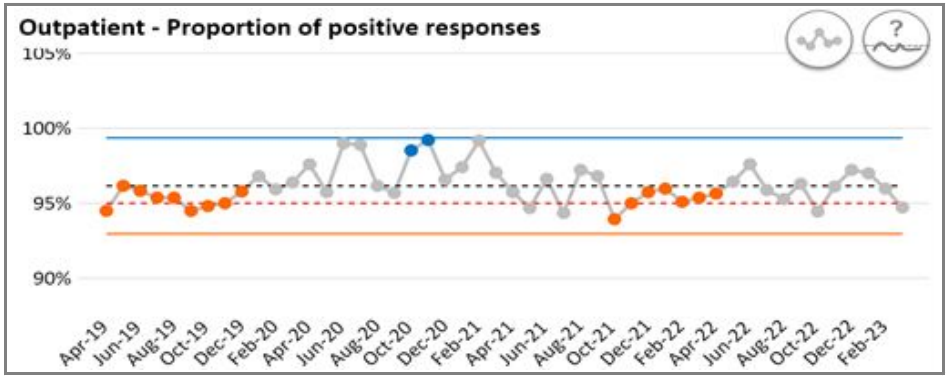


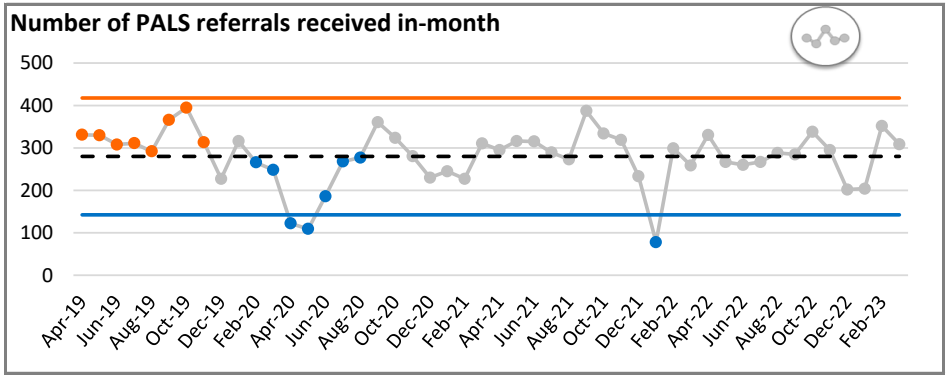
Month 12 | 2022-23

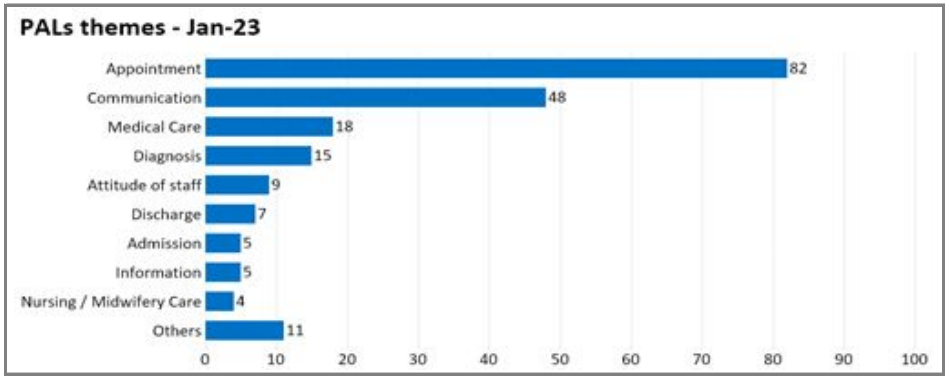
Caring Services

Friends and Family Test | Patient Advice and Liaison Service

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Friends and Family Test

Excellence

- Positive feedback about the Patient Experience team getting feedback on the wards face to face

Challenges

- Responses overall to the FFT survey for all four elements of maternity (antenatal, birth, postnatal and community midwifery) continue to be very low. Maternity are exploring ways to increase the number of responses received.

Actions

- Continue to work with ENHance to ensure that all functions and reporting systems are in place

Patient Advice Liaison Service

Excellence

- Team continue to progress through backlog of concerns as well as managing daily activity

Challenges

- PALS concerns are more complex and are taking longer to resolve
- Response rate currently over 21 days - related to volume of enquiries, team capacity and complexity of issues raised

Actions

- Continue to work on transformation plan with managing process mapping

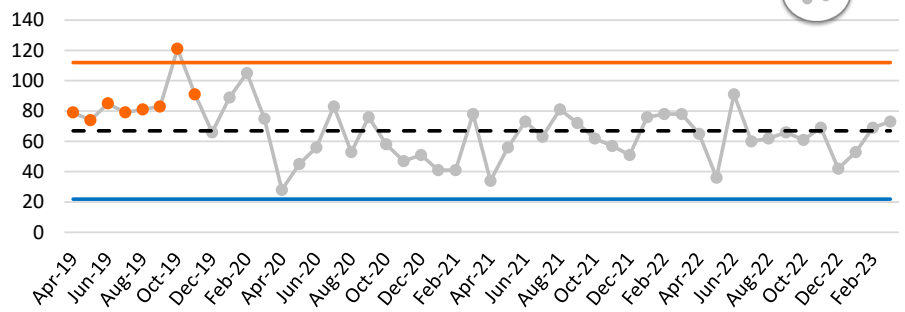
Month 12 | 2022-23

Caring Services

Complaints

East and North Hertfordshire NHS Trust

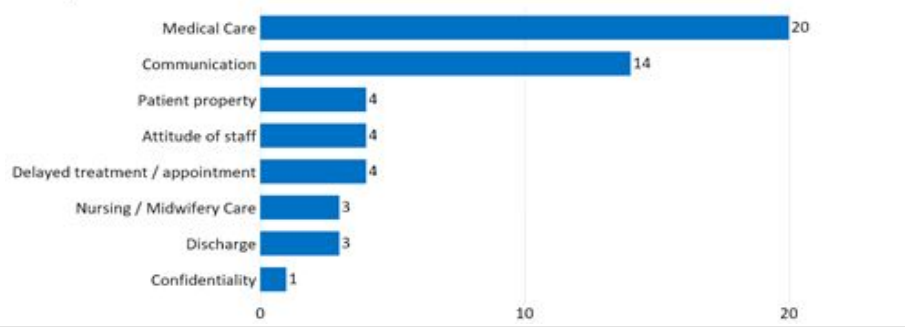
Number of written complaints received



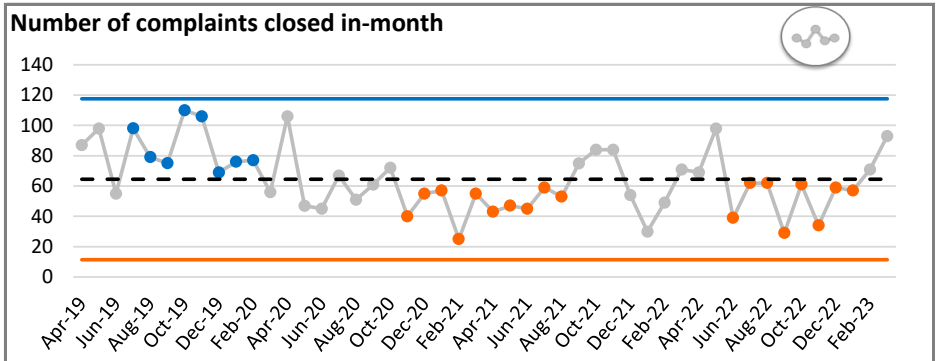
Key Issues and Executive Response

- Focus remains on drafting backlog of overdue complaints
- Working with ENHance to ensure that data is correct
- Currently 231 complaints open
- Team continuing to work hard on the backlog on drafting
- Weekly improvement meetings with each division and divisional leads starting to drive responses / closure and oversight - the 5 oldest complaints reviewed each week with expectation these are closed by the following week.

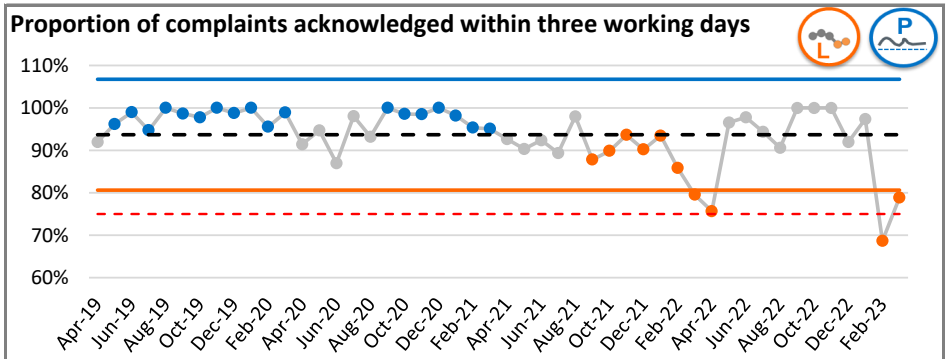
Complaints themes - Jan-23



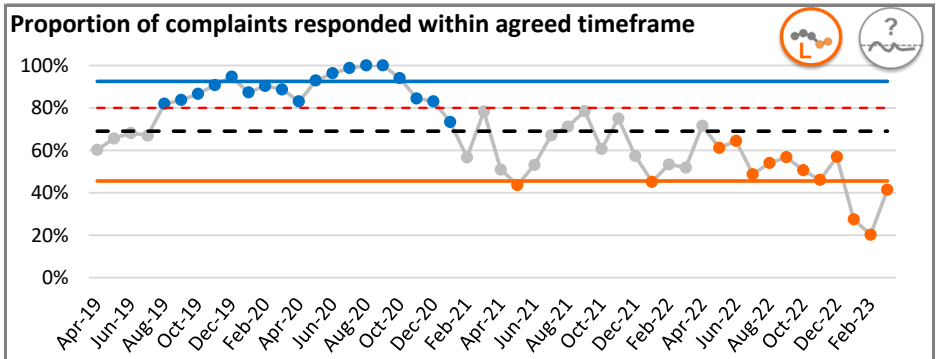
Number of complaints closed in-month



Proportion of complaints acknowledged within three working days



Proportion of complaints responded within agreed timeframe

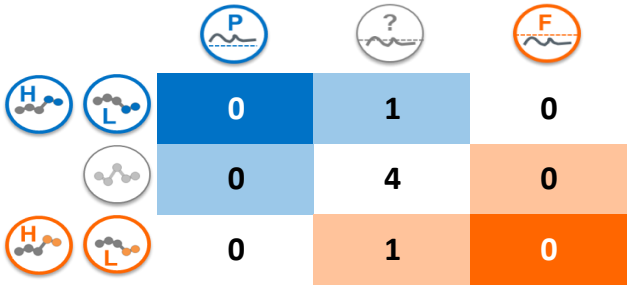


Month 12 | 2022-23

East and North Hertfordshire NHS Trust

Effective Services

Month 12 | 2022-23



Effective Services

Summary

East and North Hertfordshire NHS Trust

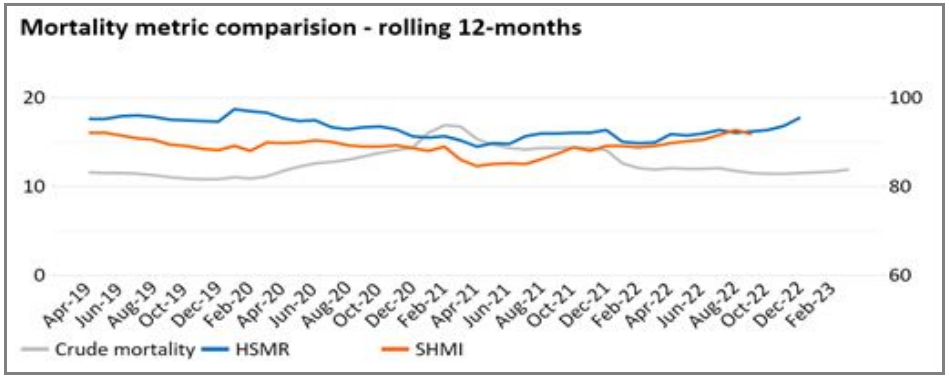
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Mortality	Crude mortality per 1,000 admissions In-month	Mar-23	12.8	14.3			Common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	Mar-23	12.8	11.9			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Dec-22	100	109.9			Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Dec-22	100	95.5			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Oct-22	100	87.8			Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Oct-22	100	90.6			Rolling 12-months - unsuitable for SPC
Re-admissions	Number of emergency re-admissions within 30 days of discharge	Dec-22	n/a	499			1 point below the lower process limit No target
	Rate of emergency re-admissions within 30 days of discharge	Dec-22	9.0%	5.5%			Two points below the lower process limit Metric will inconsistently pass and fail the target
Length of Stay	Average elective length of stay	Mar-23	2.8	2.6			Common cause variation Metric will inconsistently pass and fail the target
	Average non-elective length of stay	Mar-23	4.6	5.6			Four points above the upper process limit Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Mar-23	n/a	93.8%			8 consecutive points increasing No target
	Individualised care pathways	Mar-23	n/a	41			Common cause variation No target

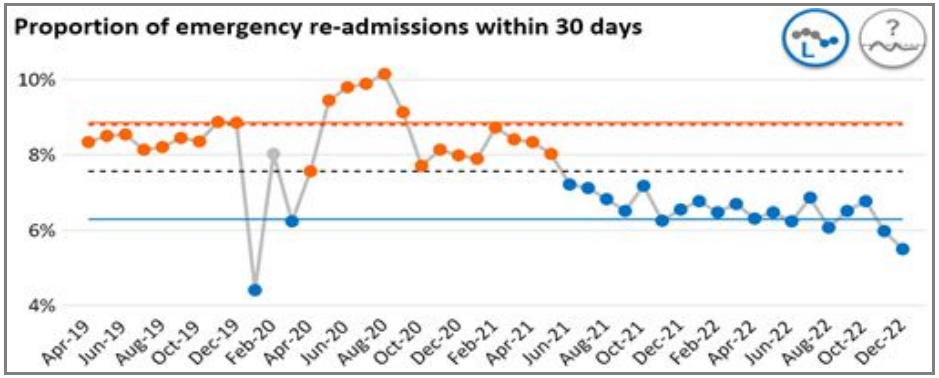
Month 12 | 2022-23

Effective Services

Mortality Summary | Emergency Re-admissions

East and North Hertfordshire NHS Trust





Key Issues and Executive Response

Mortality Metrics

- Following the rise in crude mortality seen during the pandemic, levels have now returned to pre-pandemic levels.
- Despite increases to both HSMR and SHMI we continue to be well placed vs national peers.

Learning from Deaths

- Reforms continue regarding the Trust's learning from deaths framework, including the adoption of a SJR Plus Review format, developed by NHSE which commenced on 1 July 2022. Reforms include the reduction in the number of reviews undertaken, with the focus being on gaining richer learning from the process.
- From 19 December the on-line SJR+ tool migrated from the NHSE ORIS platform to NHS Apps.
- The SJR Plus review format, adopted by the Trust in July, is very different to our previous review tool. Its adoption has provided an opportunity to revisit our broader learning from deaths processes, to take into account recent and imminent changes in the fields of scrutiny, quality, and governance, including the introduction of the Medical Examiner function and the forthcoming introduction of the new PSIRF approach to patient safety.
- To provide additional clarity and focus, a Learning from Deaths Strategy has been developed which aligns with the Trust's overarching strategy and the Quality strategy. The strategy was approved by the Mortality Surveillance Committee in November 2022. An update on progress at year-end will be included in June Learning from Deaths report to Q&SC.

Re-admissions

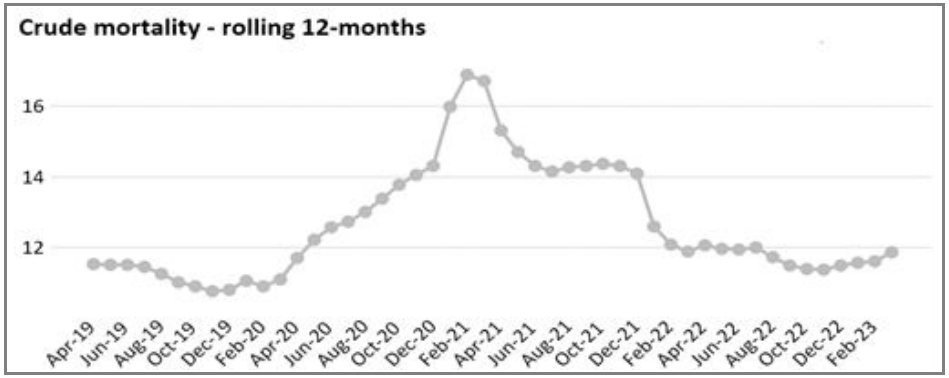
- Recent months have seen re-admissions performance improve, with the Trust consistently tracking below the national average (17 consecutive months below the mean for the number of readmissions within 30 days and 19 consecutive months below the mean for the rate of readmissions within 30 days).
- The Trust's performance is well positioned in comparison to national and our Model Hospital peer group.

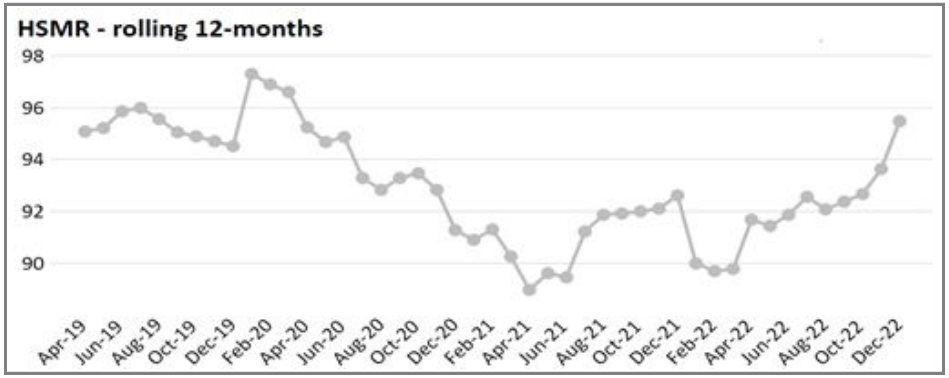
Month 12 | 2022-23

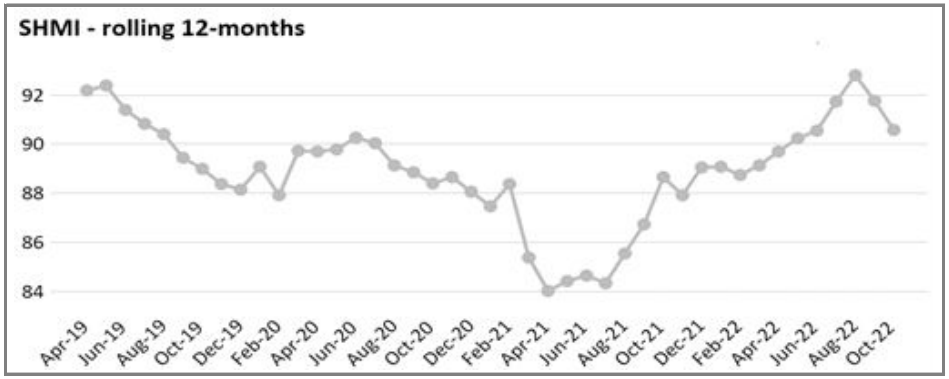
Effective Services

Mortality

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

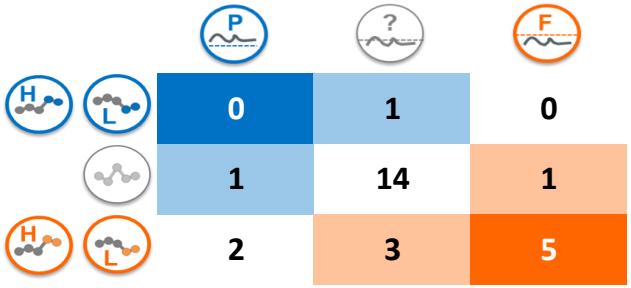
- Crude mortality is the factor which usually has the most significant impact on HSMR. The exception has been during the COVID pandemic, when the usual correlation has been weakened by the partial exclusion of COVID-19 patients from the HSMR metric.
- The general improvements in mortality prior to the COVID-19 resulted from corporate level initiatives such as the learning from deaths process, focussed clinical improvement work. Of particular importance has been the continued drive to improve the quality of our coding.
- While the COVID-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below, or in line with, the national average.
- There has been an upward trend in in-month HSMR since December 2021. This contrasts with a downward trend in crude mortality for the same period, which is unusual as HSMR tends to follow the crude metric. The reason for this is not clear but is being monitored.
- Our rolling 12-month HSMR data to February 2023 shows the Trust has remained well positioned compared to our Model Hospital Peer group. It has slipped into the mid-range of trusts nationally, although both the points and positional change are small.
- The latest in-month position for November 2022 reported by CHKS shows common cause variation.
- Latest NHSD published rolling 12-month SHMI to November 2022 showed a marginal increase from 90.59 in October to 91.13.
- This positions the Trust just outside the 'lower than expected' band, comfortably in the top quartile of trusts nationally. Despite the upward trend in SHMI, our position relative to peer has seen little change.

Month 12 | 2022-23

East and North Hertfordshire NHS Trust

Responsive Services

Month 12 | 2022-23



Responsive Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	Mar-23	95%	62.9%	L	F	14 consecutive points below the lower process limit Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	Mar-23	2%	10.0%	H	F	17 consecutive points above the upper process limit Metric will inconsistently pass and fail the target
	Percentage of ambulance handovers within 15-minutes	Mar-23	65%	10.5%	L	F	20 consecutive points below the lower process limit Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Mar-23	80%	58.9%		F	Common cause variation Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Mar-23	240	226.2	H	P	13 consecutive points above the upper process limit Metric will consistently pass the target
	Average (mean) time in department - admitted patients	Mar-23	tbc	725.7	H		7 consecutive points above the upper process limit No target
	Average minutes from clinically ready to proceed to departure	Mar-23	tbc	371			Common cause variation No target
	Critical time standards	Mar-23	tbc				Pending data
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Mar-23	92%	49.8%	L	F	18 consecutive points below the lower process limit Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Mar-23	0%	42.0%	H	F	20 consecutive points above the mean Metric will consistently fail the target

Month 12 | 2022-23

Responsive Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	Two week waits for suspected cancer	Feb-23	93%	96.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	Two week waits for breast symptoms	Feb-23	93%	100.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	28-day faster diagnosis	Feb-23	75%	76.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	31-days from diagnosis to first definitive treatment	Feb-23	96%	97.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	31-days for subsequent treatment - anti-cancer drugs	Feb-23	98%	99.4%		P	Common cause variation Metric will consistently pass the target
	31-days for subsequent treatment - radiotherapy	Feb-23	94%	94.2%	L	P	1 point below the lower process limit Metric will consistently pass the target
	31-days for subsequent treatment - surgery	Feb-23	94%	84.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	62-days from urgent GP referral to first definitive treatment	Feb-23	85%	81.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	Patients waiting more than 104-days from urgent GP referral to first definitive treatment	Feb-23	0	4.5		?	Common cause variation Metric will inconsistently pass and fail the target
	62-days from referral from an NHS screening service to first definitive treatment	Feb-23	90%	77.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	62-days from consultant upgrade to first definitive treatment	Feb-23	n/a	67.8%			Common cause variation No target

Month 12 | 2022-23

Responsive Services

Summary

East and North Hertfordshire NHS Trust

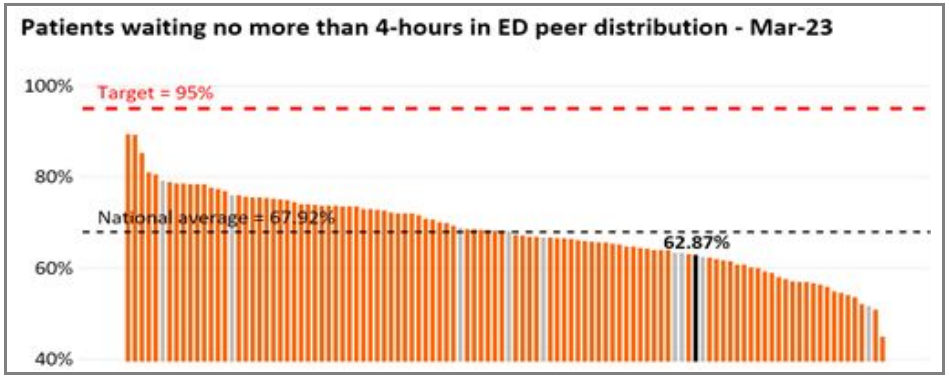
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Stroke Services	Trust SSNAP grade	Q3 2022-23	A	D			
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	Mar-23	80%	100.0%			Common cause variation Metric will inconsistently hit and miss the target
	4-hours direct to Stroke unit from ED	Mar-23	63%	15.3%	L		1 point below the lower process limit Metric will inconsistently hit and miss the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	Mar-23	63%	15.5%	L		1 point below the lower process limit Metric will inconsistently hit and miss the target
	Number of confirmed Strokes in-month on SSNAP	Mar-23	n/a	84			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Mar-23	80%	75.9%	L		1 point below the lower process limit Metric will inconsistently hit and miss the target
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Mar-23	50%	51.7%			Common cause variation Metric will inconsistently hit and miss the target
	Scanned within 12-hours - all Strokes	Mar-23	100%	100.0%	H		8 consecutive points above the mean Metric will inconsistently hit and miss the target
	% of all stroke patients who receive thrombolysis	Mar-23	11%	12.9%			Common cause variation Metric will inconsistently hit and miss the target
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	Mar-23	70%	36.4%			Common cause variation Metric will inconsistently hit and miss the target
	Discharged with JCP	Mar-23	80%	85.5%			Common cause variation Metric will inconsistently hit and miss the target
	Discharged with ESD	Mar-23	40%	66.7%			Common cause variation Metric will inconsistently hit and miss the target

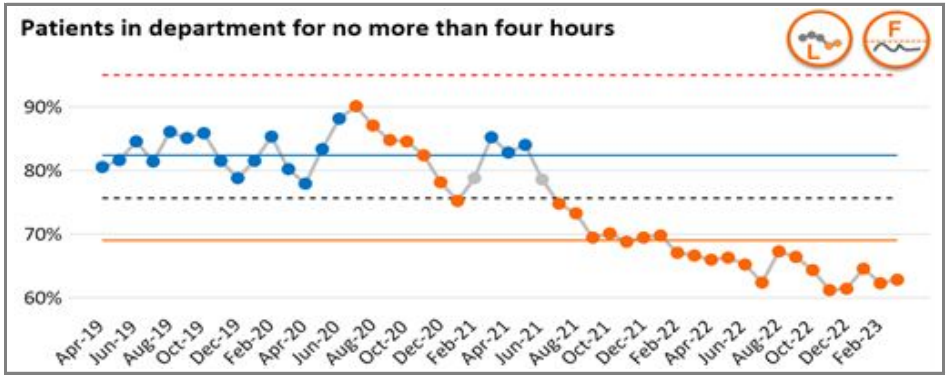
Month 12 | 2022-23

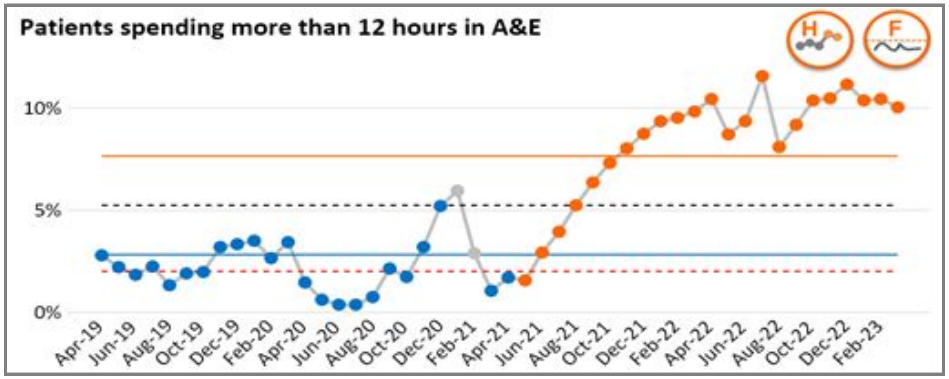
Responsive Services

Emergency Department

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

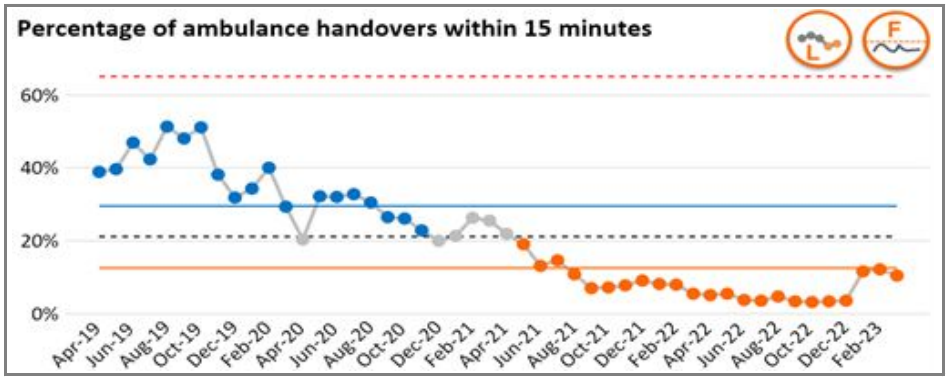
- Monthly attendances demonstrated a significant surge compared to trend at both Lister and QEII, with acuity remaining high.
- In March the first junior doctor industrial action (IA) took place, however, effective planning ensured minimal impact to UEC flow.
- Ambulance handover improvements broadly maintained, despite the highest number of arrivals compared to the last 11 months. Continued focus on reducing delays over 30 mins along with improving compliance with handovers within 15minutes. HALO vacancies have been successfully appointed to with planned starts in mid April. This will support continued and improved collaboration across both ENHT and EEast to reduce delays and improve compliance.
- SDEC activity improved with its highest level compared to last 4 months.
- Compliance with the 4 hour standard was sustained despite the increased attendances. With increased SDEC activity being a key enabler. Compliance with the 4hr standard is of significant focus with an agreed improvement trajectory over the next 12months. Key actions include a speciality assessment unit reset week scheduled in early May to enable priority flow of clinically ready to proceed and reduce average LOS and increased surgical assessment capacity. In addition the spotlight on direct to SDEC from GP referrals continues with repeat missed opportunity audits planned.
- The number of patients spending more than 12 hours in A&E was at its lowest level compared to the last 5 months, with improvement across both admitted and non-admitted average LOS.
- Bed days for patients Not Meeting the Criteria to Reside was significantly higher compared to previous months. This continues to negatively impact UEC flow.

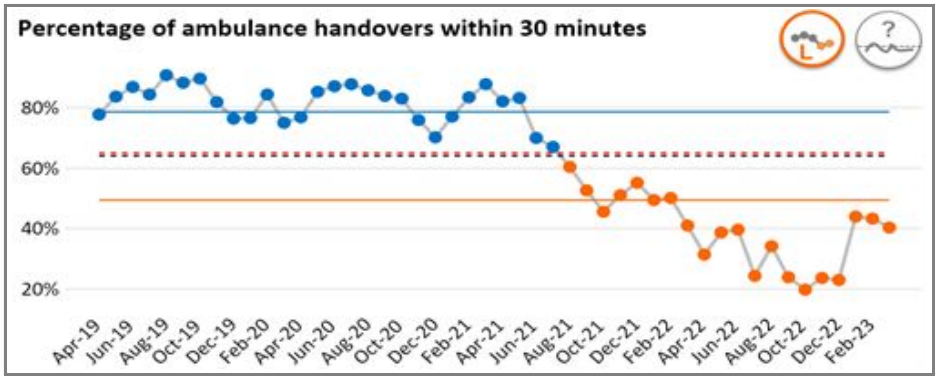
Month 12 | 2022-23

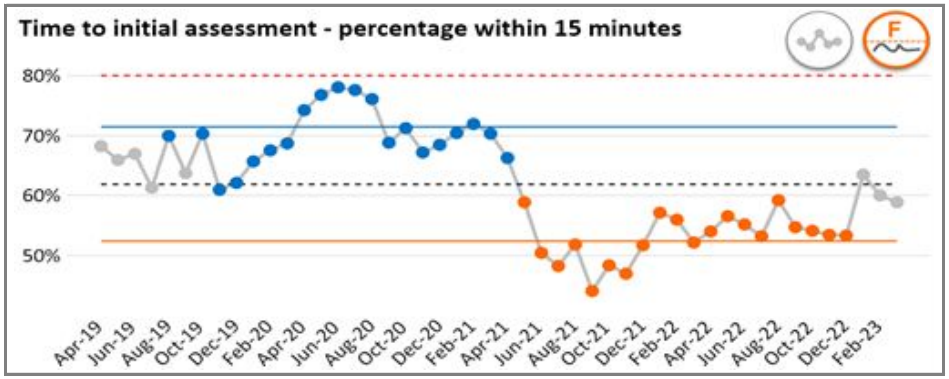
Responsive Services

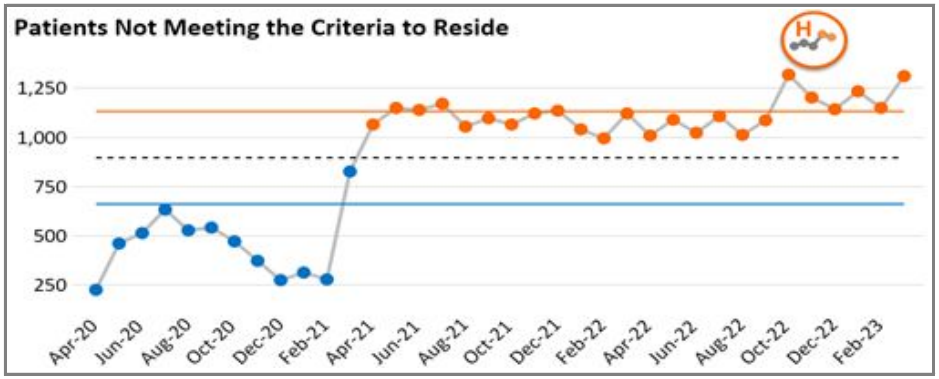
Emergency Department New Standards

East and North Hertfordshire NHS Trust







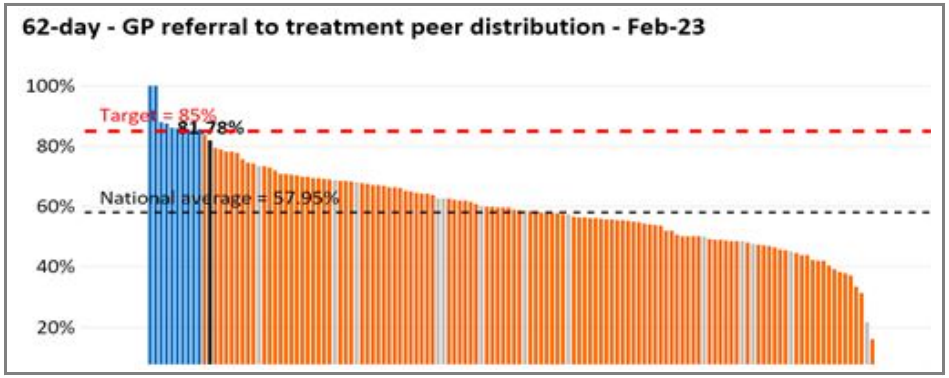


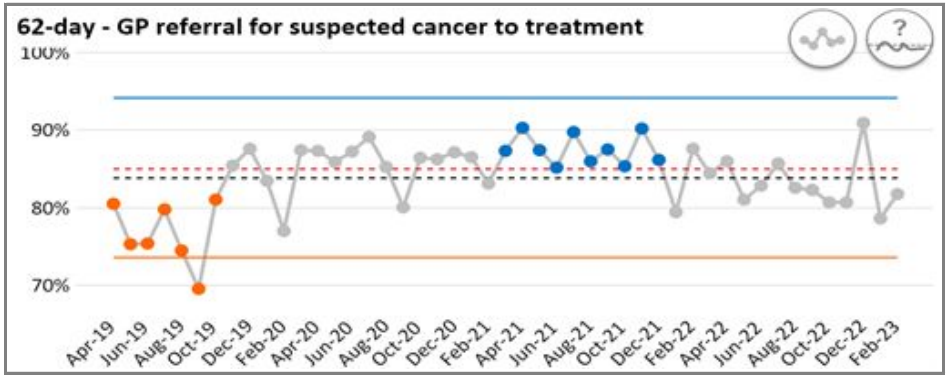
Month 12 | 2022-23

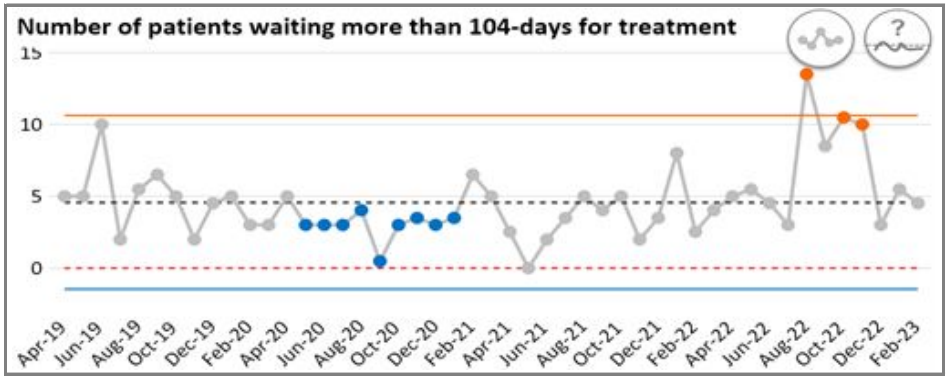
Responsive Services

Cancer Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- The Trust remains in Tier 2 based on progress in reducing the 62-day pathway backlog.
- Action plan remains in place with Breast, Skin, Upper and Lower Gastrointestinal, MDT team, Histopathology and Radiology to improve MDT follow-up, reporting and more timely communication of diagnosis and next steps, particularly for patients who after diagnosis do not have cancer.
- However, Junior Doctor strikes, staffing shortages in Anaesthetics and Breast Radiology remain an issue which will affect 62-day cancer performance and backlog for the coming months.
- Deep dives for tumour sites continue. Additional scrutiny and support leading to improved performance.
- Timed best practice pathways now in place for all Tumour sites to improve and sustain 62-day standard and deliver the Faster Diagnosis Standard performance.
- Achieved 5 of the 8 national targets in February: 2ww GP referral, 2ww Breast symptoms, 31-day first treatment, 31-day subsequent treatment for radiotherapy, 31-day second or subsequent treatment for chemotherapy
- The Trust has not achieved the 31-day subsequent for Surgery, 62-day referral to treatment for Screening due to Breast radiology delays, 62-day referral to treatment for all cancers due to patient delaying the diagnostic pathway and capacity issues due to staff shortages.
- Radiology and histopathology continue to prioritise cancer patients to avoid delays.
- The team will continue to analyse all breaches by Tumour Site to identify issues and resolve pathway delays.

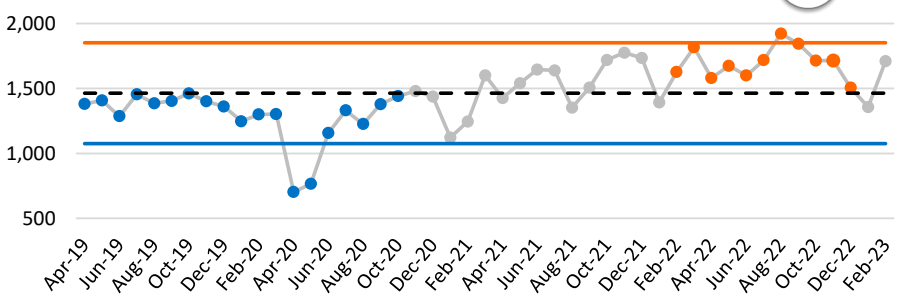
Month 12 | 2022-23

Responsive Services

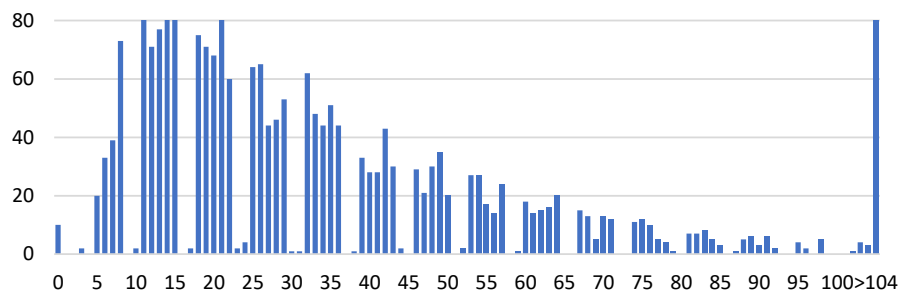
Cancer Waiting Times | Supporting Metrics

East and North Hertfordshire NHS Trust

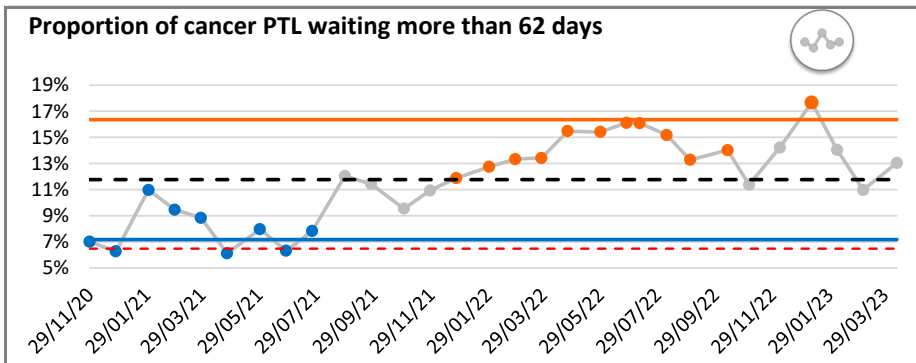
Suspected cancer referrals



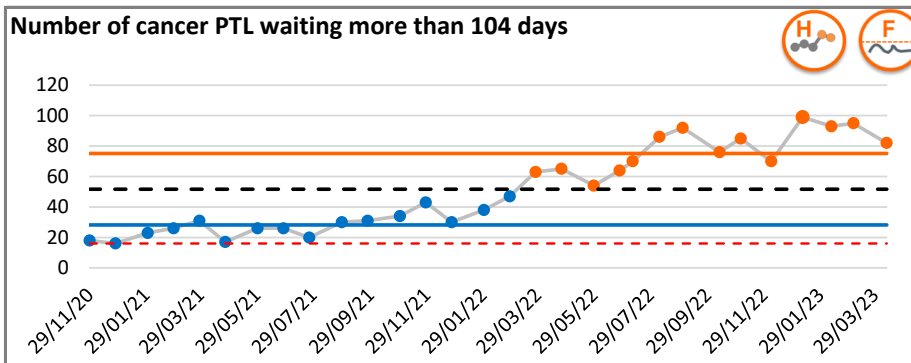
62-day PTL as at 11/04/2023



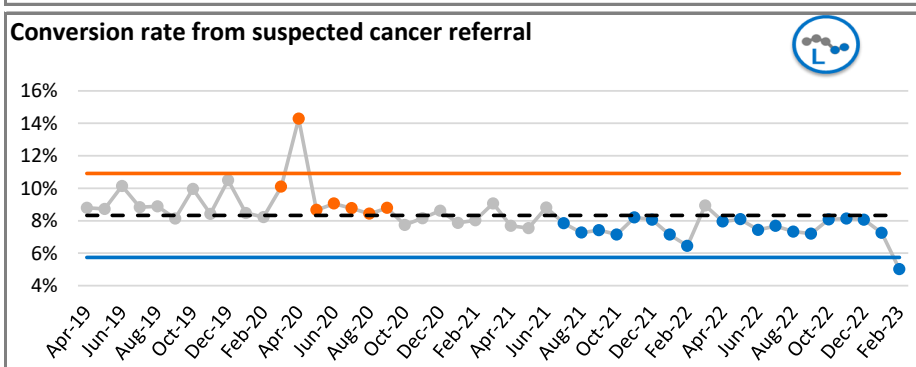
Proportion of cancer PTL waiting more than 62 days



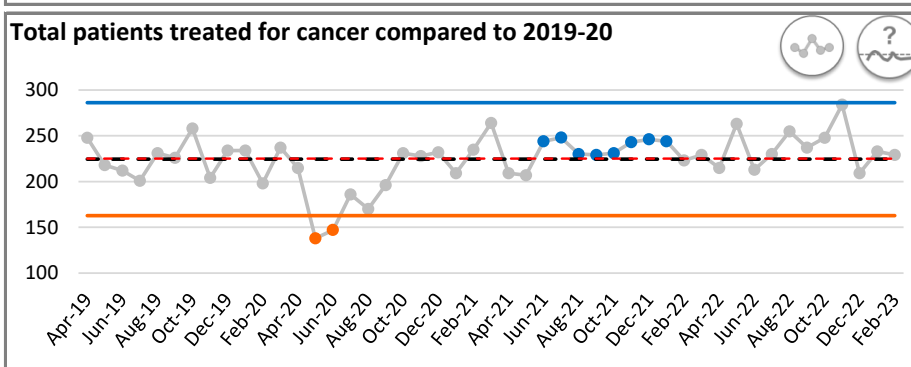
Number of cancer PTL waiting more than 104 days



Conversion rate from suspected cancer referral



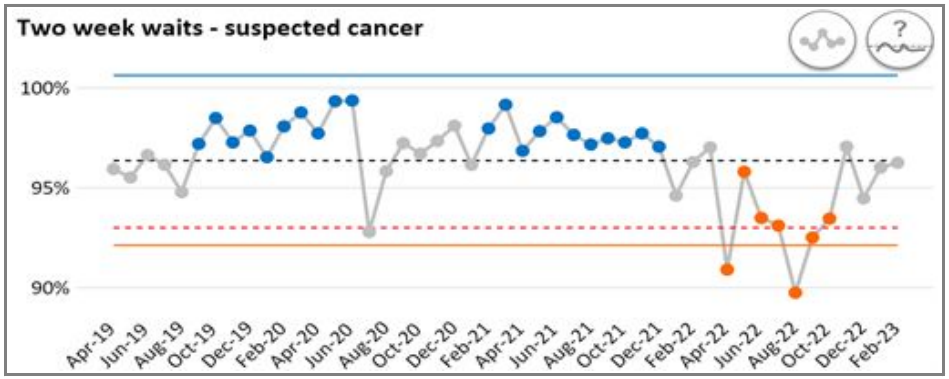
Total patients treated for cancer compared to 2019-20

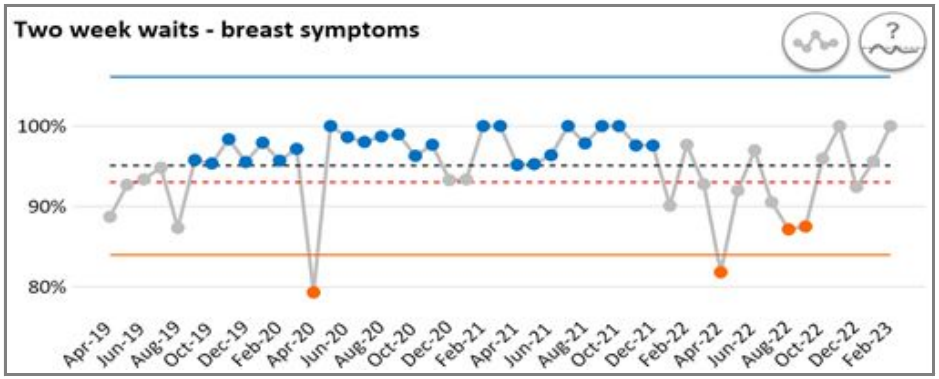


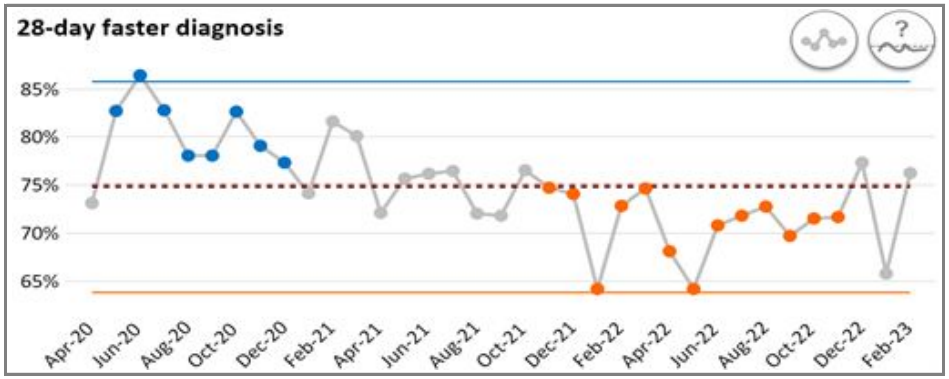
Month 12 | 2022-23

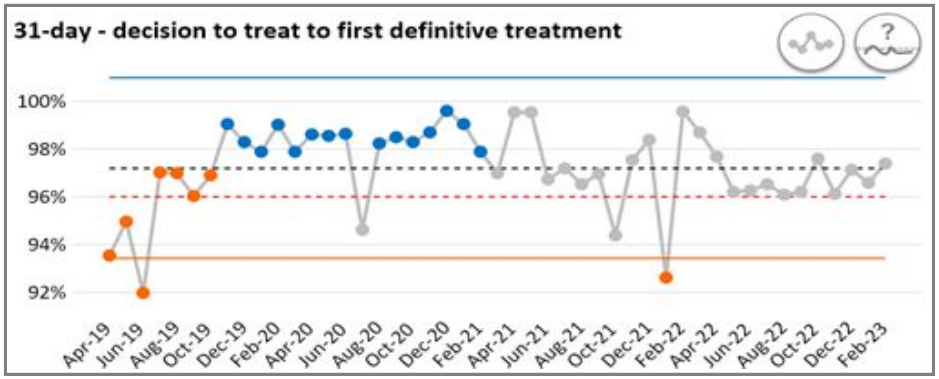
Responsive Services

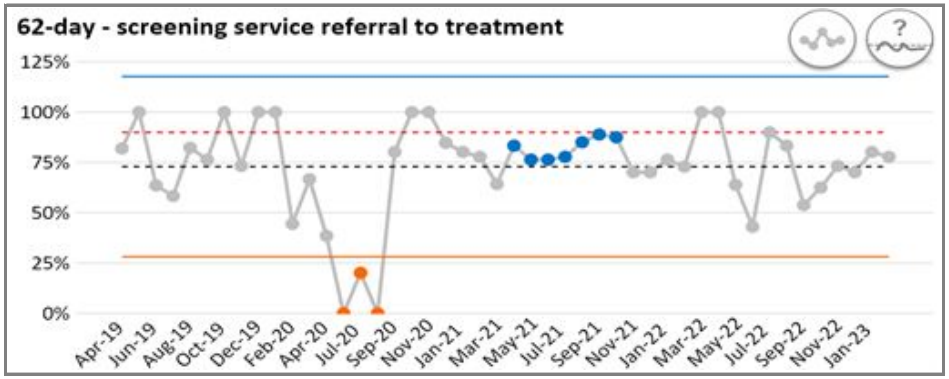
Cancer Waiting Times









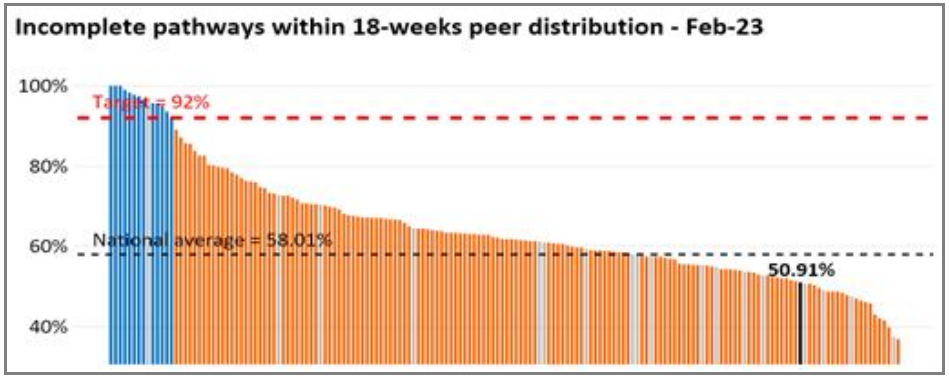


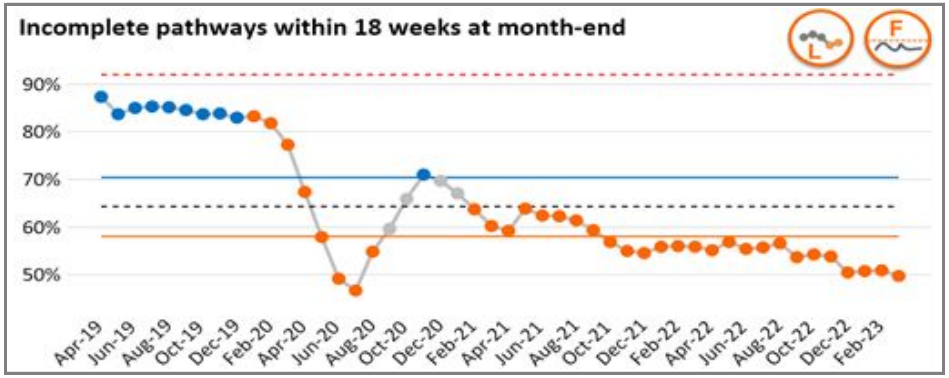
Month 12 | 2022-23

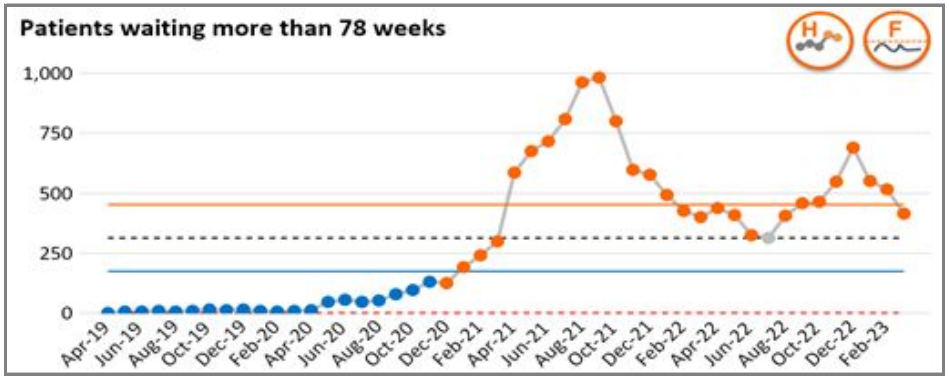
Responsive Services

RTT 18 Weeks

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

RTT Performance

- 78+ week waiters: The Trust ended the year with 405 patients waiting over 78 weeks vs the original trajectory of 554.
- The majority of the breaches were known capacity issues in Community Paediatrics, Trauma and Orthopaedics and Gastroenterology.
- 24 patients were delayed due to patient choice and complexity of the patient pathway.
- The number of patients waiting 78+ weeks for an appointment is 0.66% of total RTT PTL.
- 104+ week waiters: There were 0 patients waiting 104 weeks at the end of March.

Data Quality

- Patients waiting over 40 weeks are validated and all patients without an updated validation comment in the last 12 weeks are reviewed.
- All patients waiting 70 weeks+ are actively managed with the services.

Activity

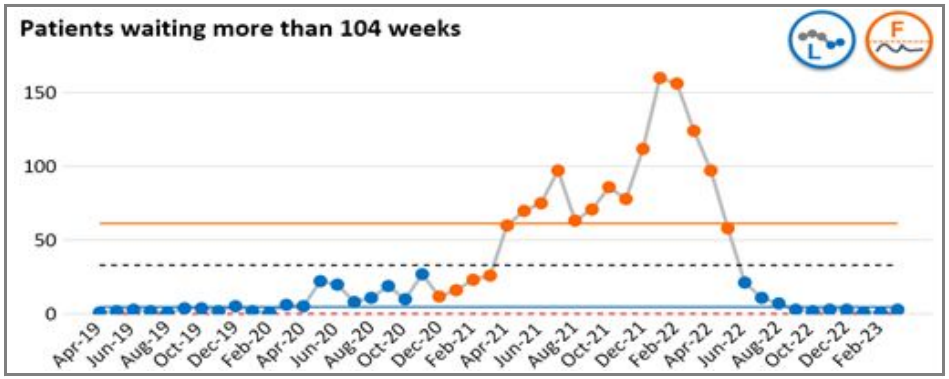
- Referrals received have remained above the mean since Sep-21.
- Advice and Guidance has continued to increase above the upper control limit
- Patient Initiated Follow Up (PIFU) episodes continue to increase.
- New to follow-up ratio has remained stable below the lower control limit
- Outpatient and Day Case activity has increased in month.
- Inpatient activity has remained stable in month.
- Theatre cases per list have increased slightly in month.

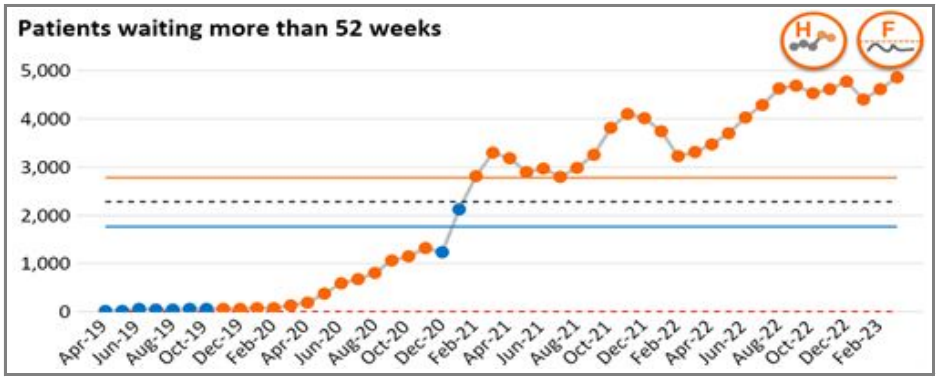
Month 12 | 2022-23

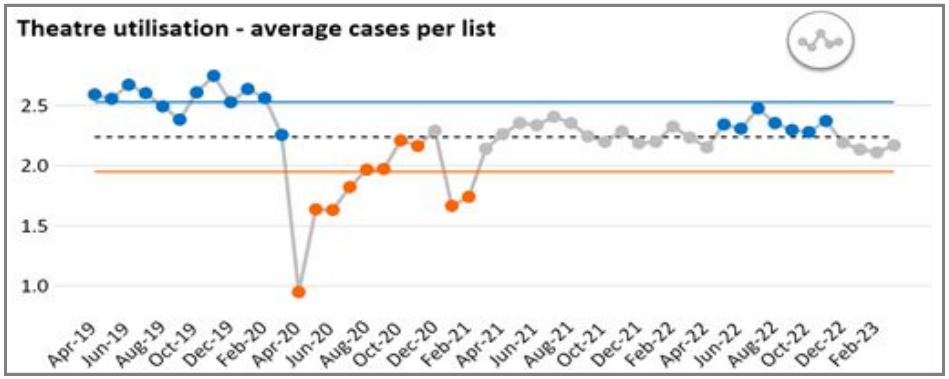
Responsive Services

RTT 18 Weeks Supporting Metrics

East and North Hertfordshire NHS Trust





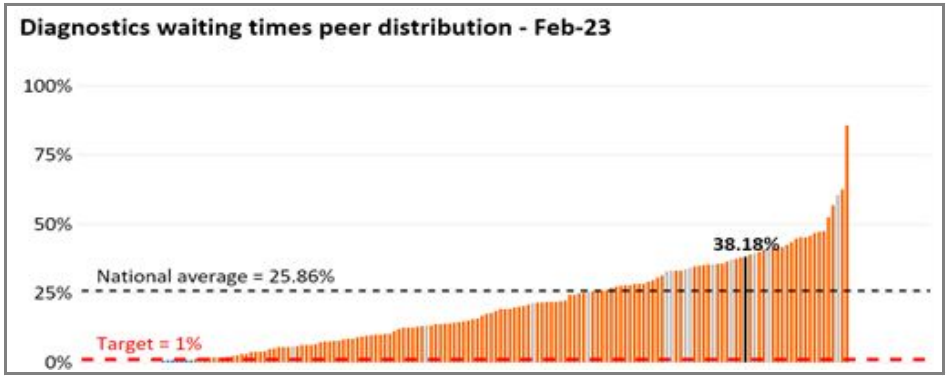


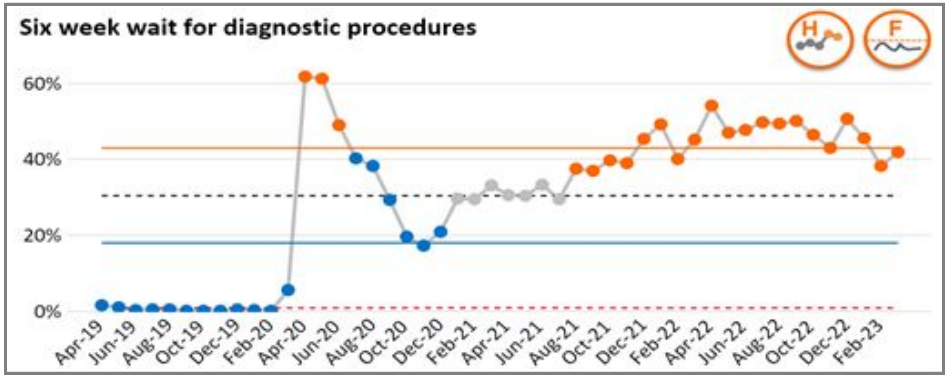
Month 12 | 2022-23

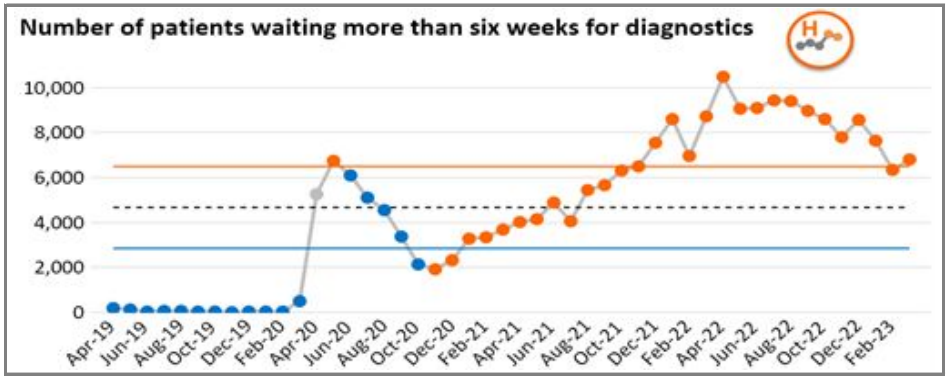
Responsive Services

Diagnostics Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Improvements

- Overall demand in Mar is 11.7% higher compared with Feb demand (events), likely due to Feb being a shorter month. There has been 19% increase in cancer demand and 9.8% in acute demand.
- Community Diagnostic Centre (CDC) activity continues to meet trajectory or overdeliver for imaging, with positive patient feedback.
- There is 11% increase in completed activity (events) compared with Feb.
- Continued focus on reducing Endoscopy routine and urgent waiting times
- Echo backlog is now clear. Waiting time for new referrals is approx. 10 wks. Plan in place to clear back to 6 weeks with additional capacity being put on.

Challenges

- CT1 is near end of life, and breakdown rate has increased. This is currently mitigated by CT4 although there are still safety equipment that need to be put in place (alarm).
- Continued sustained increase in cancer demand for CT, MRI & US, impacting ability to regain compliance with diagnostic waits within 6 weeks (DM01) at a faster pace.
- Endoscopy - Managing long waits for non-cancer following increases in 62 day pathway patients. Managing balance + risk.
- Increased referrals for 2ww and routine endoscopy diagnostics
- Risk to echo compliance due to challenges with recruitment to vacant posts to support 7 day working.
- CDH ECHO - implementation plans pending Go Live due to digital issues for GP requesting and access to reporting with ICE configuration aligned to upgrades.

Actions

- Further MRI/CT radiographer training in CT/MRI
- Trajectory in place to open the 6th room in QE11 from 11th May 2023
- Ongoing monitoring of echo backlog and capacity to support DM01 compliance

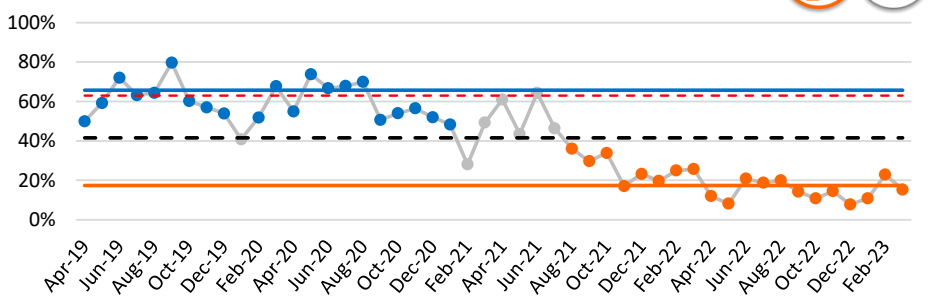
Month 12 | 2022-23

Responsive Services

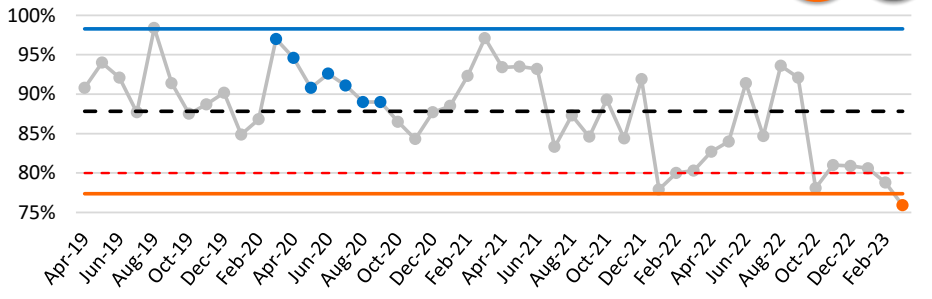
Stroke Services Supporting Metrics

East and North Hertfordshire NHS Trust

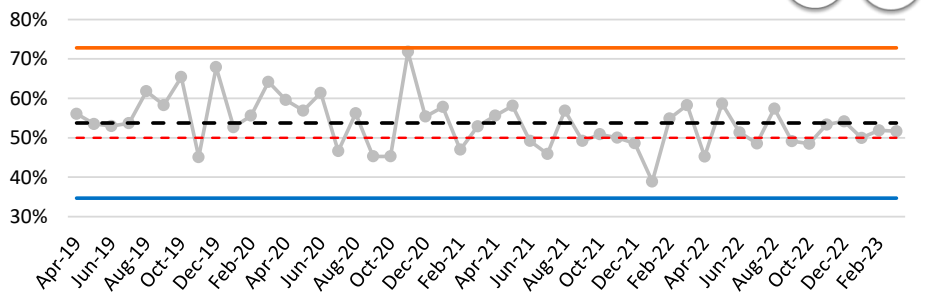
4-hours direct to Stroke unit from ED



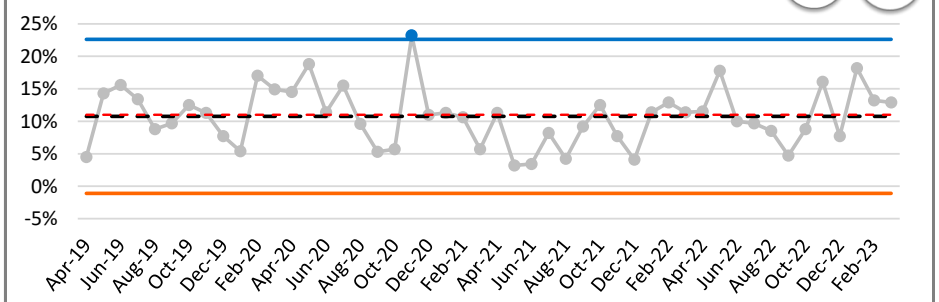
If applicable at least 90% of patients' stay is spent on a stroke unit



Urgent brain imaging within 60-mins for suspected acute stroke



% of all stroke patients who receive thrombolysis



Key Issues and Executive Response

- Admission directly from ED to the stroke unit remains an area where performance is not at the required standard. This is also recognised as a national issue.
- Trust implementation of changes to covid testing within the Trust, is reducing the delay from ED to the stroke unit admission when capacity is available.
- Capacity issues and operational pressures across the organisation also contributed to performance against this standard, particularly ambulance handover delays, despite stroke nurses assessing patients whilst still in the ambulance.
- There was a decline in month on the thrombolysis pathway: the percentage of patients treated and Door to Needle time. This was due to ED pathways and challenges with demand.
- Physiotherapy and Occupational Therapy increased service provision and we have seen ongoing improvements in performance.
- In HCT's commissioned service for speech and language, there are capacity issues due to ongoing workforce shortages.

Month 12 | 2022-23

NHS
East and North Hertfordshire
NHS Trust

People

Month 12 | 2022-23

	P	?	F
H / L	0	0	1
	0	1	1
H / L	0	4	0

People

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Mar-23	5%	9.1%	H	?	Seven points above upper process limit Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Mar-23	10%	10.6%		?	Common cause variation Metric will inconsistently pass and fail the target
	Agency spend as a proportion of WTE	Mar-23	4%	5.4%	H	?	One point above the lower process limit Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Mar-23	90%	87.2%		F	Common cause variation Metric will consistently fail the target
	Appraisal rate	Mar-23	90%	66.2%	H	F	Nine consecutive points rising trend Metric will consistently fail the target
Thrive	Turnover rate	Mar-23	12%	11.5%	H	?	17 consecutive points above the mean Metric will inconsistently pass and fail the target
Care	Sickness rate	Mar-23	3.8%	5.4%	H	?	Nine points above the mean Metric will inconsistently pass and fail the target

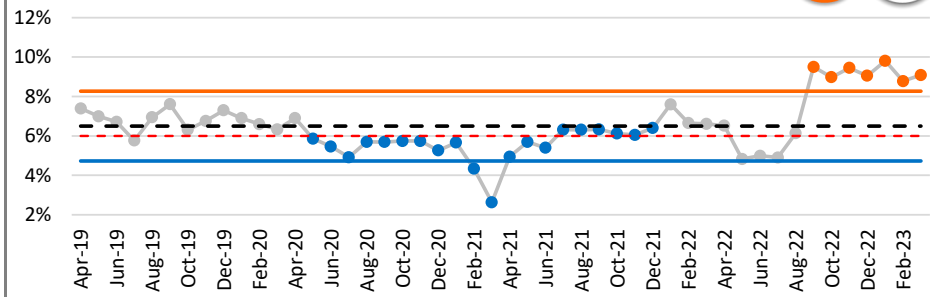
Month 12 | 2022-23

People

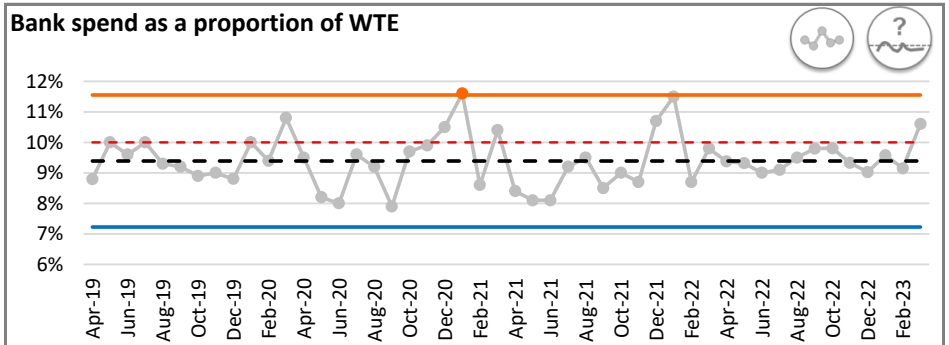
Work Together

East and North Hertfordshire NHS Trust

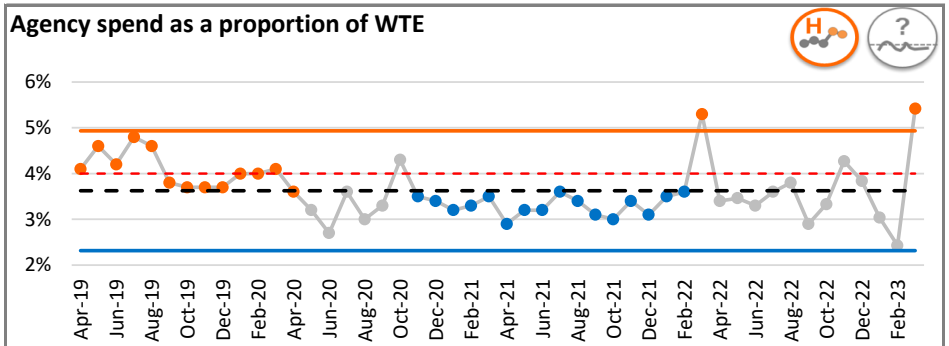
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- Vacancy Rate increased slightly to 9.1% due to 20 leavers, no change to recruitable vs M11, however there are 185 more staff in post than March 2022. Overall, the trust remains 4.1% above target.
- Nursing & Midwifery vacancy rate has improved to 7.6%, with an additional 24 qualified staff starting in M12. 1,863 is the highest number of Qualified staff in post for 3 years, this continues to be achieved through a very successful overseas recruitment campaign with 18 nurses arriving in month as well as improvements in the uptake of students.
- Overall turnover reduced to 11.5% - 1.5% off Trust target with the lowest turnover rate since July 2022.
- Concluded year end, £1.3m overspend against agency ceiling target (£12.4m) - this was primarily due to significant increases in M11 & 12 within Cancer, Unplanned & W&C, although a significant spend in M12 within Corporate relating to Imaging Network (Operations) and IT.
- Significant reconciliations of data sets are underway, triangulating eroster, temporary staffing, resourcing and finance information to ensure robust governance and exit/conversion strategies are in place to support CIPs and Workforce Plans ambitions for 23/24.
- Awarded the NHS Pastoral Care Quality Award - to recognise our work in international recruitment and the ongoing commitment to providing high-quality pastoral care to internationally educated nurses and midwives during recruitment processes and their employment.
- 'Start Date Ready' functionality now live within our TRAC system - ensuring our new starters have a seamless & positive onboarding experience linked to readiness
- Enquire (our People Virtual Assistant) was shortlisted for a HSJ Digital Award from over 300 submissions - award ceremony in June.

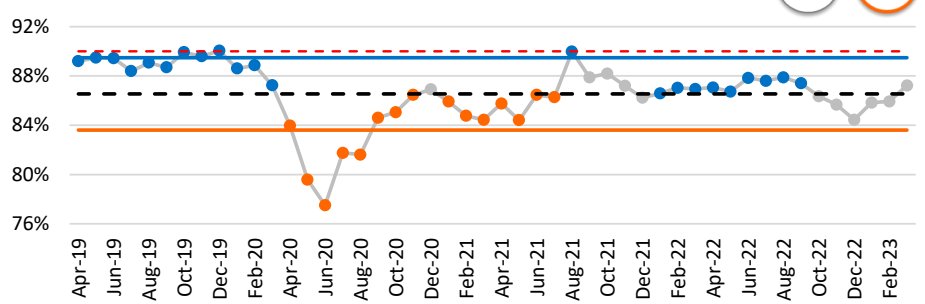
Month 12 | 2022-23

People

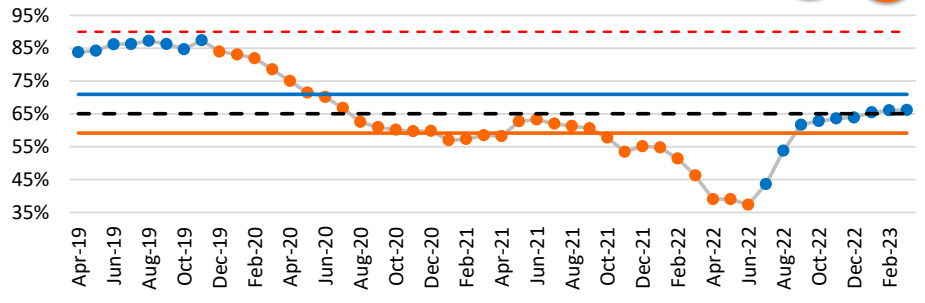
Grow Together

East and North Hertfordshire NHS Trust

Statutory and mandatory training compliance rate



Appraisal rate



Key Issues and Executive Response

- The Trust's appraisal window opened in April 2023, work continues through promotion and training events to increase awareness and address queries. Our priority this year will be focussing on reporting and targeting areas to increase compliance and meet the 90% target, currently at 66%.
- Mandatory training has shown an increase this month to 86.5%. Direct e-mail reminders are being sent out to staff that are non-compliant and their managers, over the next few months, to coincide with the appraisal window.
- Areas of concern which have been flagged and discussed at the Statutory Training Committee include low compliance for medical staff with most courses and low compliance in maternity and ED. Local trajectories have been developed and are being monitored at improvement committees.
- The team is awaiting confirmation from HEE on 23/24 CPD funding allocation for non medical training, which is expected by May/June 23. However the £690k allocation from 22/23 has been fully utilised, with courses provided to Nursing and other clinical professions.

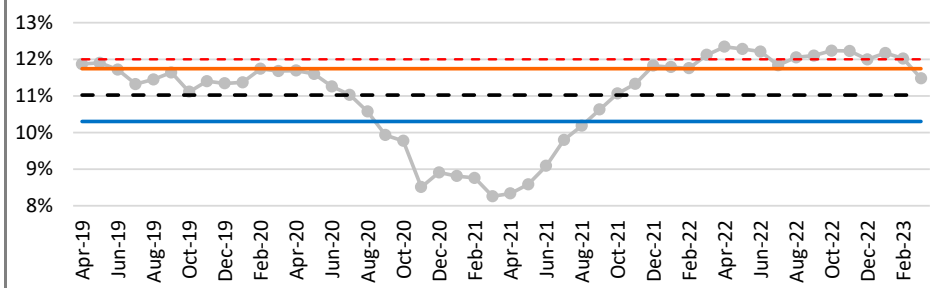
Month 12 | 2022-23

People

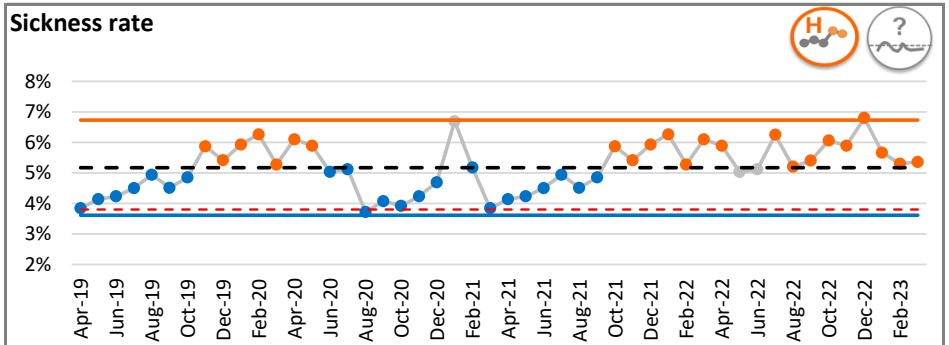
Thrive Together | Care Together

East and North Hertfordshire NHS Trust

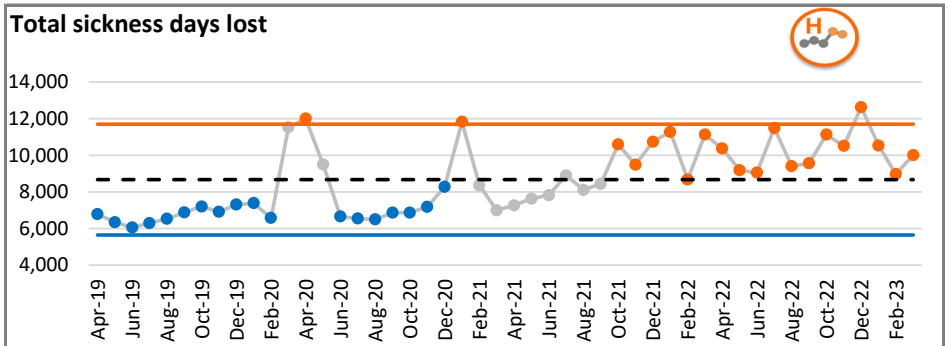
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- Hydration box scheme has started and been well received, with two packing and collection dates per planned beyond April throughout 2023/24
- Review of the staff community shop is underway to explore how to retain the facility for staff as funding came to an end in March 2023

Care Together

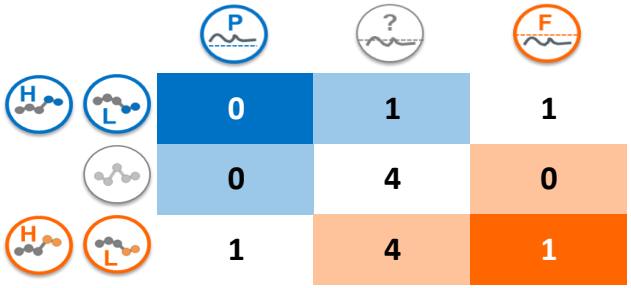
- Staff survey data has been published and shows 6 people promise domains below average, ENHT will focus on Team, Always Learning and Compassionate and Inclusive and work continues across other domains and plans in place to increase engagement further in this years staff survey
- Team talks and cascade of staff survey well underway with local actions being agreed and monitored through local divisional board packs
- Reductions in management and conclusion of case work continues and plans in development to create trained investigators and mediators across ENHT in 23/24
- Regular long term sickness reviews and work on short term sickness management continues and shows some traction in supporting staff and managers.

Month 12 | 2022-23

East and North Hertfordshire NHS Trust

Sustainable Services

Month 12 | 2022-23



Sustainable Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Mar-23	-2.4	-1.26		?	Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	Mar-23	1,245	930			Common cause variation No target
	Cash balance	Mar-23	77.9	74.0	H	F	2 points above the upper process limit Metric will consistently fail the target
Key Financial Drivers	Income earned	Mar-23	45.3	64.9	H	?	1 point above the upper process limit Metric will inconsistently pass and fail the target
	Pay costs	Mar-23	29.5	45.7	H	?	2 points above the upper process limit Metric will inconsistently pass and fail the target
	Non-pay costs (including financing)	Mar-23	15.5	20.4	H	?	15 consecutive points above the mean Metric will inconsistently pass and fail the target

Month 12 | 2022-23

Sustainable Services

Summary

East and North Hertfordshire NHS Trust

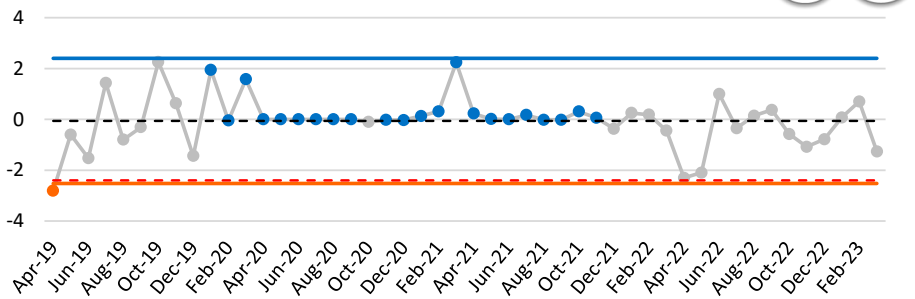
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	Mar-23	24.9	39.7	H	?	2 points above the upper process limit Metric will inconsistently pass and fail the target
	Average monthly substantive pay costs (000s)	Mar-23	0.9	6.8	H	F	1 point above th eupper process limit Metric will consistently fail the target
	Agency costs	Mar-23		1.7	H		1 point above the upper process limit No target
	Unit cost of agency staff	Mar-23		16.7	H		1 point above the upper process limit No target
	Bank costs	Mar-23	3.7	4.3	H	P	1 point above the upper process limit Metric will consistently pass the target
	Overtime and WLI costs	Mar-23	0.5	0.4		?	Common cause variation Metric will inconsistently pass and fail the target
Other Financial Metrics	Elective Recovery Fund income earned	Mar-23	1.1	2.4		?	Common cause variation Metric will inconsistently pass and fail the target
	Drugs and consumable spend	Mar-23	2.8	4.2	H	?	1 point above the upper process limit Metric will inconsistently pass and fail the target
	Private patients income earned	Mar-23	0.4	0.5		?	Common cause variation Metric will inconsistently pass and fail the target

Sustainable Services

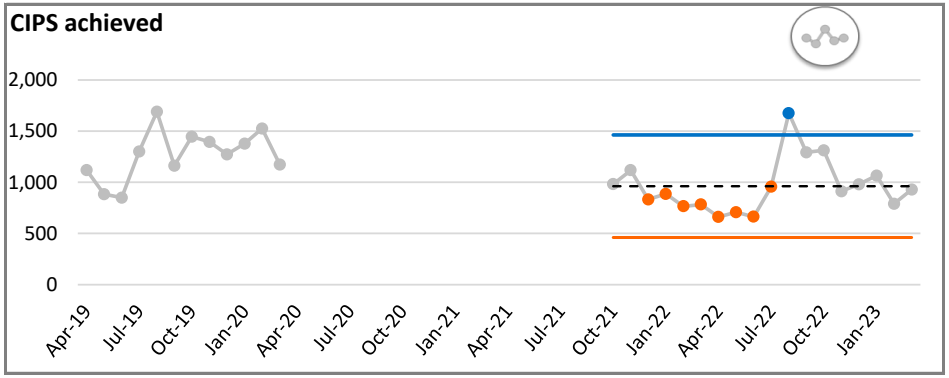
Summary Financial Position

East and North Hertfordshire NHS Trust

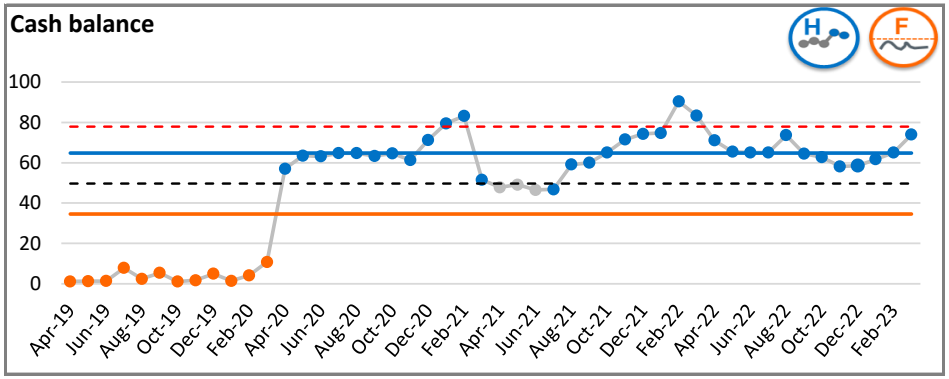
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

- The Trust is reporting a £6.1m deficit at the end of the financial year, against a break-even plan. This is subject to audit verification.
- The £6.1m reported deficit was £0.8m favourable to the £6.9m forecast deficit, which was submitted, and agreed, by the ICB and NHSE.
- After stripping out the impact of non recurrent items and reserves benefits which have been included in the 2022/23 reported position, it is clear that the Trust has a significant underlying deficit challenge, that flows through into the development of its 23/24 financial plan.
- CIP performance remains poor with a final reported CIP delivery of £12.0m compared with a plan of £18.8m. Of the £12.0m CIP delivery only £5.4m has been delivered recurrently. This puts further pressure on the 2023/24 plan as the CIP target is expected to be recurrently delivered.
- Capital expenditure was slightly lower than the Capital Resource Limit (CRL) which had been allocated to the Trust.

	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	543.1	569.1	26.0
Pay	-352.9	-373.9	-21.0
Non Pay	-183.3	-196.1	-12.8
EBITDA	6.9	-0.9	-7.7
Financing Costs	-32.4	-31.9	0.5
Retained Deficit exc. PSF	-25.5	-32.8	-7.2
Top-Up Payments	10.0	11.1	1.1
Systems Funding	15.5	15.6	0.0
Surplus / Deficit (excl Fin Adj's)	0.0	-6.1	-6.1

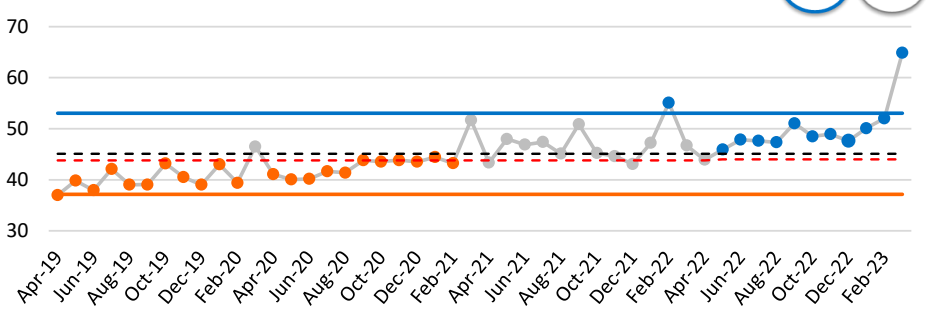
Month 12 | 2022-23

Sustainable Services

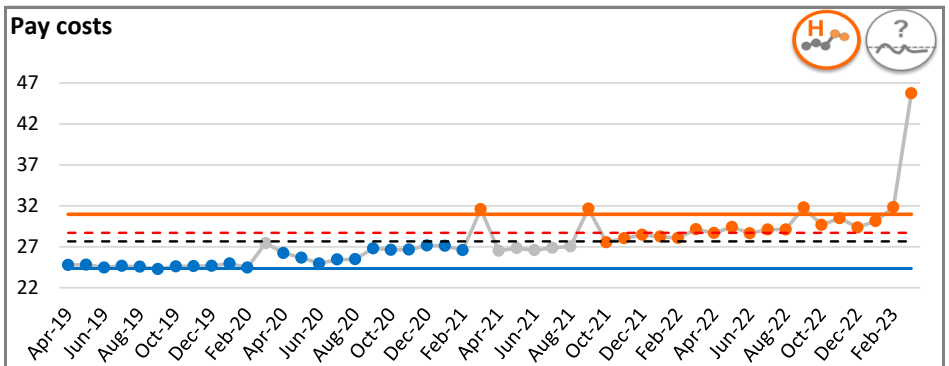
Key Financial Drivers

East and North Hertfordshire NHS Trust

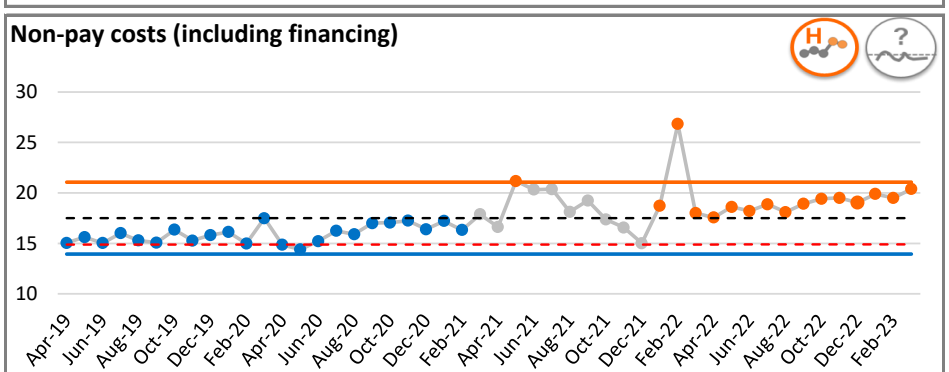
Income earned



Pay costs



Non-pay costs (including financing)



Key Issues and Executive Response

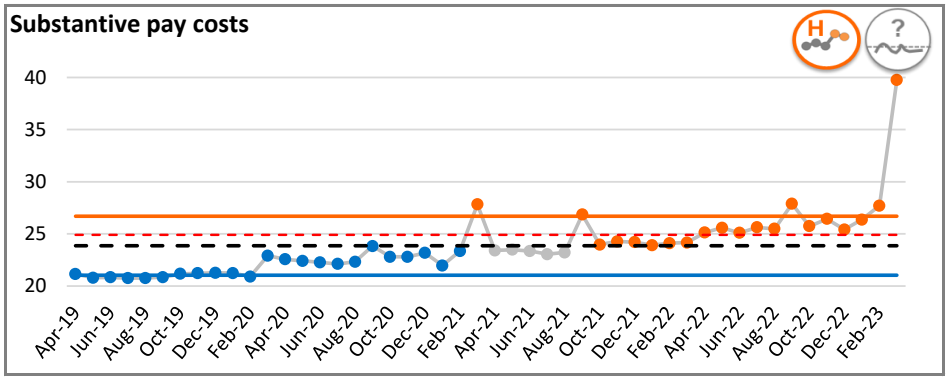
- The Trust reports a year end deficit of £6.1m at Year End. This is a variance against its breakeven target, although is within the deficit target that it agreed with HWE ICB and NHSE during Q4.
- The year end deficit has been underpinned by the contribution of a significant value of non recurrent reserves benefits, and as such the Trust exits 22/23 with a material underlying deficit, which contributes to the planning challenge for 23/24.
- Under delivery against CIP targets has been a consistent feature across 22/23. At year end the Trust reports a shortfall of £6.8m against its CIP targets. In addition only 30% of the CIP target has been achieved on a recurrent basis and this again adds further to the 23/24 challenge.
- The Trust has delivered its ERF income target across the full year and has agreed its year end position with both HWE ICB and NHSE.
- Elective performance was particularly strong in the first half of the year, but dropped markedly during H2 as a consequence of the ongoing dispute associated with enhanced payment rates.
- The impact of inflation upon Trust expenditure during the year has been marked with costs pertaining to utilities and drugs being in excess of those anticipated within the plan.
- In line with National guidance, the month 12 position includes a £11.4m provision for the impact of the proposed 2022/23 non consolidated pay award, which has not yet been paid or agreed by all unions. This has been largely offset by additional £11m funding, which has been centrally calculated.
- Given a range of significant risk items that potentially compromise the delivery of the financial plan, the Trust has initiated a programme of 'Financial Reset'. This encompasses a number of work streams that target the improvement of the present run rate.
- The activities of the programme are over seen by an Executive Steering Group and supported by divisional reset meetings.

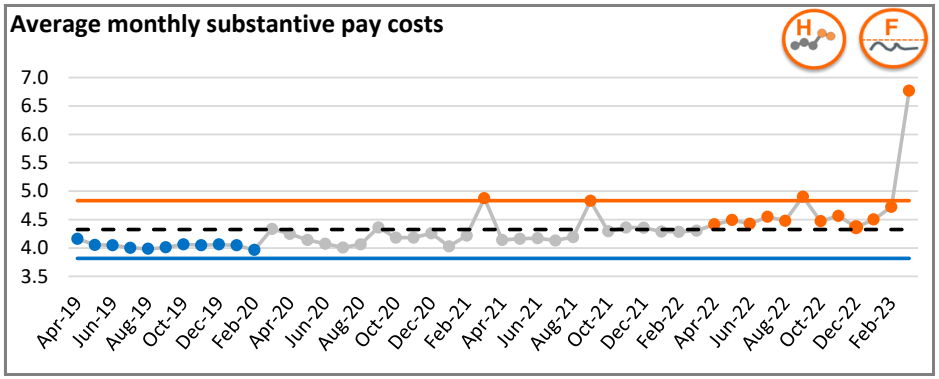
Month 12 | 2022-23

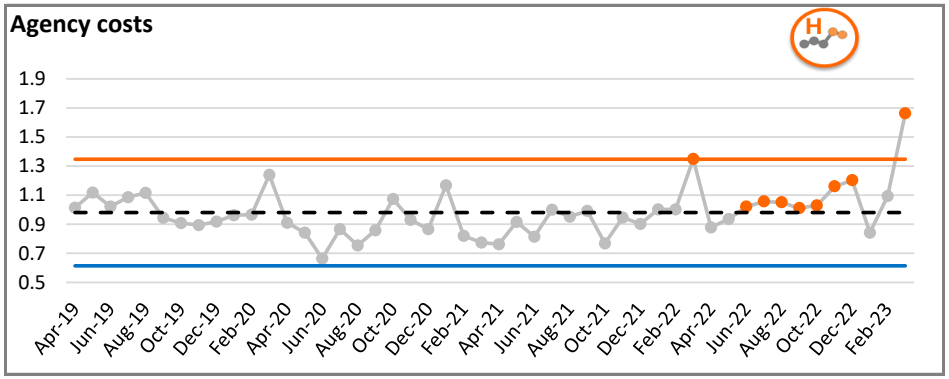
Sustainable Services

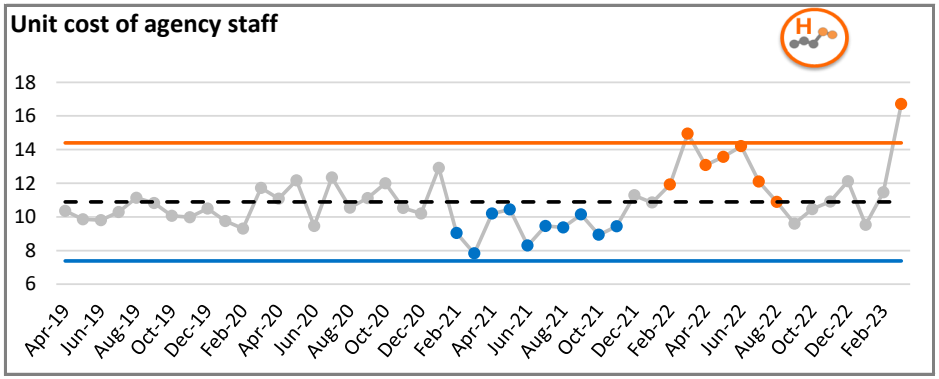
Other Financial Indicators

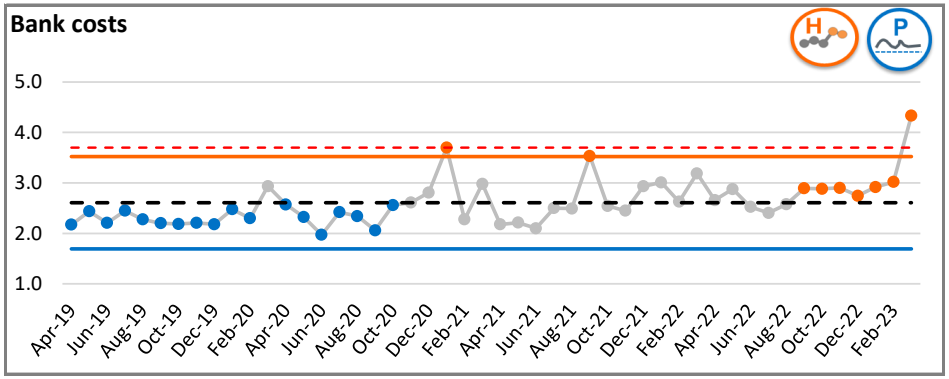
East and North Hertfordshire NHS Trust

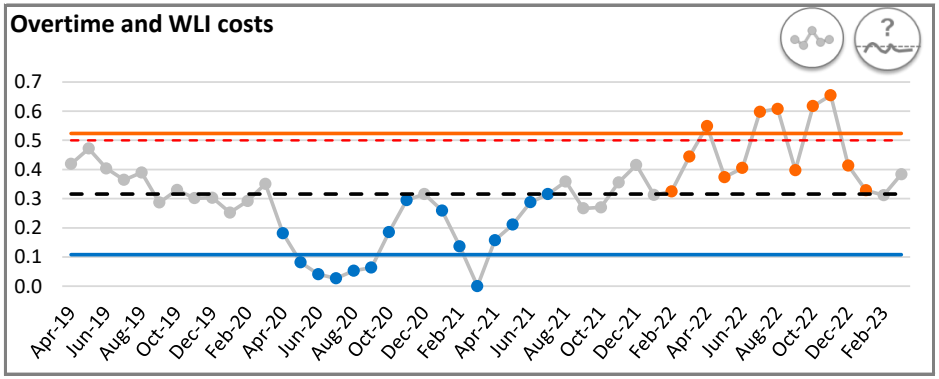












Month 12 | 2022-23

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	15
Report title	ICS Monthly Performance Report			**Meeting Date**	3 May 2023
Presenter	Martin Armstrong - Deputy CEO				
Author(s)	Herts and West Essex – Integrated Care System				
Responsible Director	Martin Armstrong – Chief Finance Officer			**Approval Date**	23-02-23
Purpose *(tick one box only)*	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

The report attached is produced by Hertfordshire and West Essex integrated care system and sets out performance against a range of access dimensions across the system and the organisations that compose its membership.

Impact: where significant implication(s) need highlighting

The board is asked to note system performance issues and challenges, within the context of ENHT delivery.

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

NA

Report previously considered by & date(s):

NA

Recommendation	The Board is asked to note the report

To be trusted to provide consistently outstanding care and exemplary service

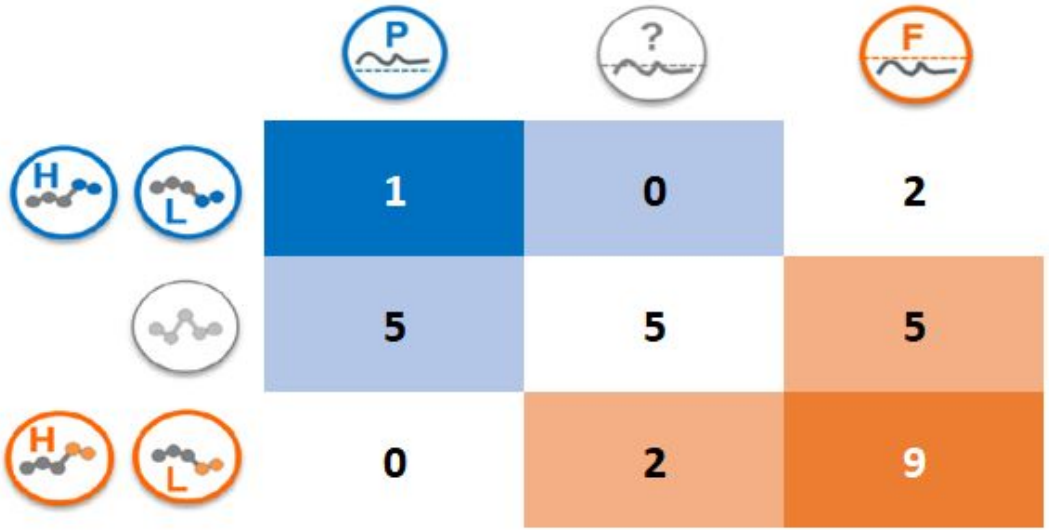
Hertfordshire and West Essex Integrated Care System

Presentation to: HWE ICB Board
HWE ICS Performance Report

March 2023

Working together
for a healthier future

Executive Summary – KPI Risk Summary



Highest Risk	Programme
ED 4 Hour Standard	UEC
% in ED > 12 Hours	UEC
Ambulance Handovers	UEC
Ambulance Response Times	UEC
6 Week Waits	Diagnostics
Out of Area Bed Days	Mental Health
Adult 28 Day Standard	Mental Health
HPFT Early Memory Diagnosis (EMDASS)	Mental Health
RTT 52 Week Waits	Elective

Lowest Risk	Programme
RTT 104 Week Waits	Elective

Low Risk	Programme
2 Hour UCR	UEC
90% Stroke Unit	Stroke
Mental Health EIP	Mental Health
Adult Crisis 4 Hour	Mental Health
CHC Assessments in Acute	Community

Variable Risk	Programme
Dementia Diagnosis	Primary Care
GP Appointments	Primary Care
28 Day Faster Diagnosis	Cancer
62 Day Backlog	Cancer
Community Waits (Adults)	Community
CHC Assessments < 28 Days	Community
RTT 78 Week Waits	Elective

High Risk	Programme
% Not Meeting CTR	UEC
NHS 111 Calls	UEC
4 Hour Stroke Unit	Stroke
Thrombolysed < 1 Hour	Stroke
2 Week Waits	Cancer
62 Day Standard	Cancer
Community Waits (Children)	Community

Executive Summary

URGENT CARE, Slides 7-13: Calls abandoned performance = worse than national and regional position; ED 4 hour performance = better than regional position but worse than national position

- In line with a significant increase in demand related to Strep A, 111 performance against calls abandoned and calls answered declined in December, however improvements have been seen in January;
- Cat 2 mean ambulance response times further deteriorated in December reaching over 2 hours. Although ambulance handover performance remains poor, improvements have been seen in Nov and Dec;
- ED 4 hour performance declined further in December however saw an improvement in January; whilst remaining worse than the national position, the latest performance has improved above the regional average and to just under the ICS performance improvement trajectory. An improvement was also seen in the % of patients spending more than 12 hours in department in the latest data, although the position remains high. ED attendances continue above historical averages however did see a decline in January;
- Data suggests that plans are starting to deliver small improvements in some areas however overall performance against improvement trajectories for UEC remains off track.

CANCER, Slides 21-22: 62 day first performance = better than regional and national position

- Improved performance levels continue to be delivered against 28 day Faster Diagnosis Standard with performance improving to just under the 75% national ambition in December at 74.7%;
- Although continuing below standard, December also saw a return to improved 62 day first performance with the ICB ranking the 7th highest nationally; ENHT returned to meet the 85% standard delivering 91%. The number of patients waiting >62 days improved in January following an increase in December, however remains behind recovery plan which is at risk;
- ENHT have been de-escalated from Tier 1 to Tier 2 in line with performance improvements and WHTHT have been removed completely from the tiering system with consistent week on week improvements.

PLANNED CARE, Slide 18: 18 week performance = worse than regional and national position

- Continued delivery of 104 week recovery with zero capacity breaches;
- Number of patients waiting over 78 weeks increased in December with activity falling just behind recovery trajectory; pressure remains predominantly in Trauma and Orthopaedics and Community Paediatrics at ENHT which are not forecast to meet 0 by March 23. Further potential risk to 78 week trajectory from Industrial Action. WHTHT and ENHT have been de-escalated from Tier 1 to Tier 2 for 78 week recovery;
- The number of patients waiting over 52 weeks decreased in December ending an 8 month upward trend, however remain high and of concern.

DIAGNOSTICS, Slide 19: 6 week performance = worse than regional and national position

- Data does not show a significant improvement in diagnostic position with a static PTL and performance declining against standard and national benchmarking;
- System-wide diagnostic improvement plan in place, including recovery trajectories for all challenged modalities. All modalities are expected to be 6 week compliant by March 23 with exception of Audiology, Non-Obstetric Ultra Sound, MRI (ENHT), ECHO (WHTHT) and DEXA (WHTHT and ENHT) with longer recovery trajectories in place.

Community, Slides 14-17

- Decline in number of adults on total list waiting list in December with an improvement also seen in proportion waiting <18 weeks; longest wait of 67 wks in adults and 71 weeks in children;
- Increase in number of children on total waiting list in December with percentage waiting <18 weeks remaining low; pressures remain in community paediatrics, therapies and audiology services.
- Widening inequalities in timely access to community services between adult and children patient groups.

MENTAL HEALTH, Slides 26-32

- Demand continues to remain high in Adult, Older Adult and CAMHS services, however has started to stabilise together with demand for crisis services which is returning to historic baselines;
- Pressure for Mental Health Assessments and acute beds continues, with Out of Area Bed Days continuing to remain high; a decrease was seen in December however;
- Dementia diagnosis remains challenged in Hertfordshire however has seen an improvement in performance in the latest data;

PRIMARY CARE AND CONTINUING HEALTHCARE, Slides 33-34

- Total number of GP appointments remain higher than pre-pandemic levels although did see a decline in December, potentially due to the holiday period. The proportion of face to face appointments continue to increase, reaching over 70% for the last three months;
- The number of CHC assessments completed within 28 days remains a challenge in South West Herts with a decline in performance in December

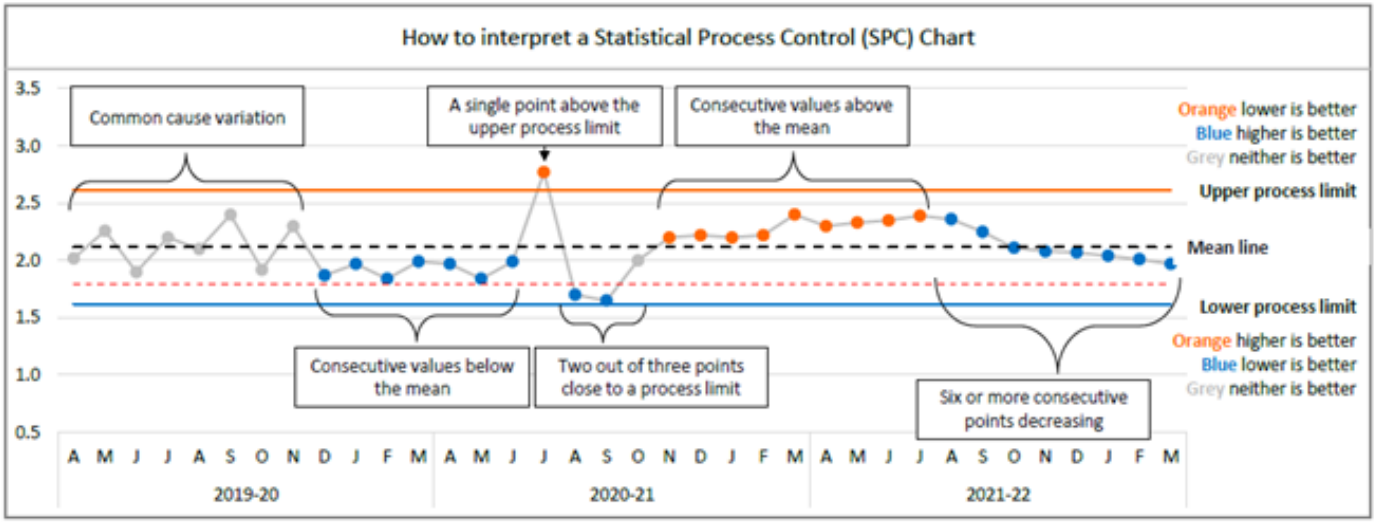
Executive Summary – Performance Overview

Metric	Latest month	Measure	Variation	Assurance	Mean	Lower process limit	Upper process limit
A&E - 4 Hour Standard	Jan 23	63.5%			67.3%	61.6%	73.0%
A&E - % spending more than 12 Hours in Dept	Nov 22	8.8%			6.6%	4.9%	8.2%
A&E - ED Average Attendance	Jan 23	37036			40307	33906	46708
Trolley Waits	Jan 23	225			180	-37	396
2 Hour Community Response	Dec 22	77.7%			83.5%	67.2%	99.7%
14 day LOS	Dec 22	26.2%			25.0%	21.0%	29.0%
Ambulance - Handover >60 Mins	Dec 22	1178			948	665	1231
EEAST: Cat 1 - Mean (<7min)	Dec 22	00:11:55			00:09:41	00:08:03	00:11:20
EEAST: Cat 2 - Mean (<18 Mins)	Dec 22	02:00:45			00:55:25	00:20:54	01:29:55
RTT - 18 Weeks	Dec 22	50.3%			57.8%	54.6%	61.1%
RTT - 52 Week Waits	Dec 22	10095			7101	5617	8586
RTT - PTL Size	Dec 22	137708			120457	112719	128195
RTT - 78 weeks	Dec 22	915			1018	674	1362
Diagnostics - 6 Week Wait	Dec 22	57.7%			64.9%	57.1%	72.7%
Diagnostics - PTL Size	Dec 22	22185			24610	19900	29319
Cancer - 2 Week Wait Standard	Dec 22	85.4%			80.0%	67.3%	92.6%
Cancer - 2 Week Wait Referrals	Dec 22	4439			5230	4036	6423
Cancer - 62 Day Standard	Dec 22	74.0%			74.3%	65.5%	83.2%
Cancer - 62 Day Total Waiting	Jan 23	577			610	388	833
Cancer - 104 Day Total Waiting	Jan 23	202			153	102	205
Cancer - 28 Day Faster Diagnosis Standard	Dec 22	74.7%			69.4%	59.2%	79.6%
Mental Health - Out of Area Bed Days	Dec 22	1289			900	539	1261
Mental Health - Dementia Diagnosis	Dec 22	62.3%			61.5%	60.9%	62.2%
Mental Health - IAPT Entering Treatment	Dec 22	1815			2389	1557	3222
Early Intervention in Psychosis	Dec 22	70.0%			83.6%	66.3%	101.0%

A Dashboard including Place and Trust based performance is included within Appendix A of this report

4

Statistical Process Control (SPC)



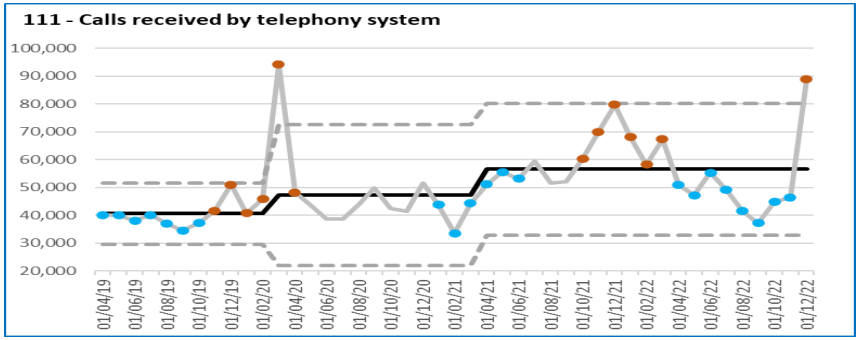
Variation	
H L	Special cause variation of concerning nature due to Higher or Lower values
H L	Special cause variation of improving nature due to Higher or Lower values
	Common cause variation No significant change

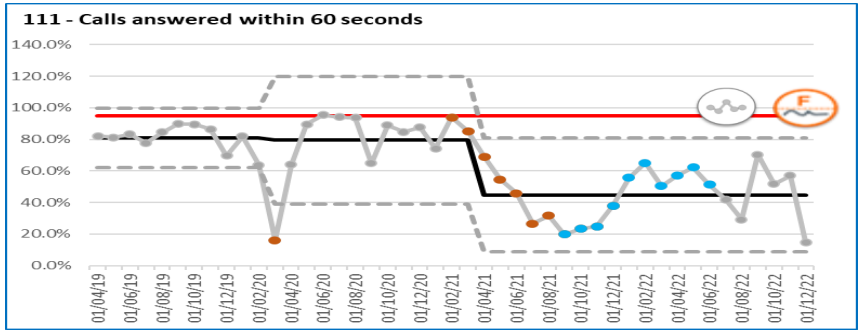
Assurance	
F	Consistent Failing of the target Upper / lower process limit is above / below target line
P	Consistent Passing of target Upper / lower process limit is above / below target line
?	Inconsistent passing and failing of the target

5

Performance by Work Programme

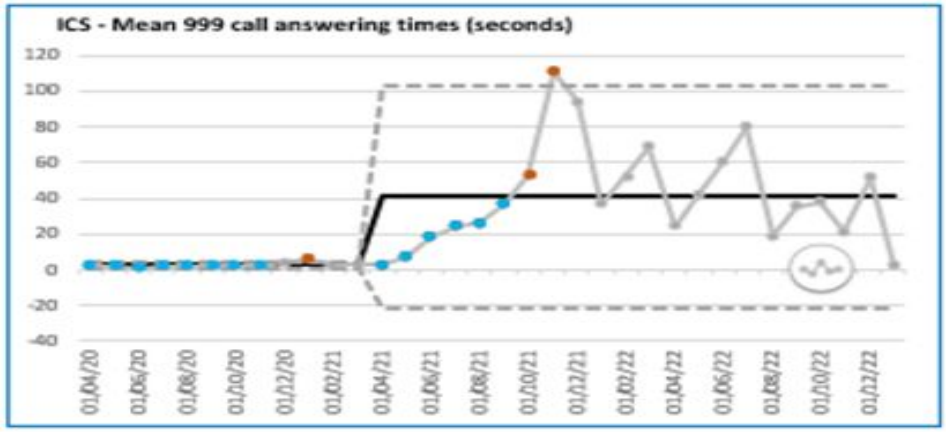
NHS 111

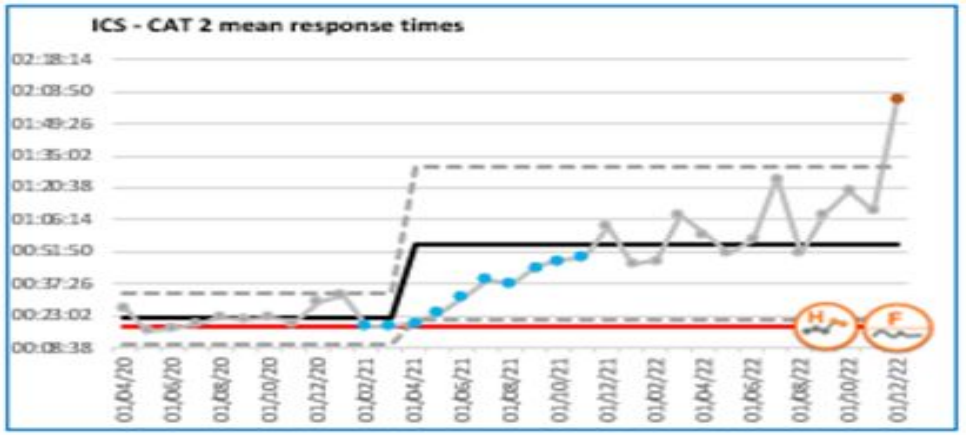


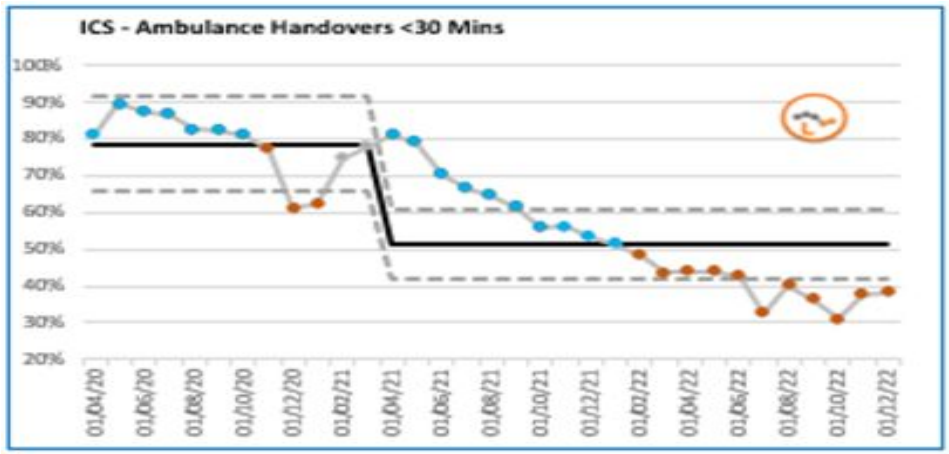


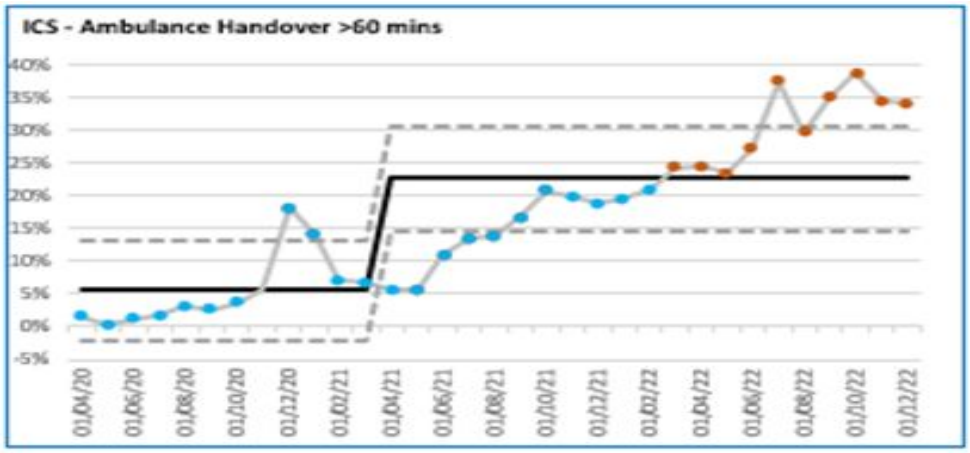
ICB Area	What the charts tell us	Issues	Actions	Outcomes
HUC	• Unprecedent spike in calls received by NHS111 in December. Linked to the National Strep A alert • 50-60% of all calls were answered within 60 seconds in October / November. This dropped to c.15% in December. January 23 data shows significant improvement to c.50% • Abandoned calls also increased significantly in December – up to c.45% against the 5% standard. As above, January is showing considerable improvement to c.15%	• Critical Incident declared in December due to significant increase in call volumes • Staffing issues due to the unprecedented number of calls • Strep A alert contributing towards high call volumes, longer queues and higher abandonment rates	• Escalation calls established to manage response in respect of high call volumes in December • Mutual Aid requests sent out by the Provider; both within HUC organisation and outside • Respiratory Hubs established until end of March 2023 to divert activity away from 111 and ED • Weekly IUC Overview Reports from the Provider with monthly updates on workforce • Non-critical meetings and reporting stood down in January to allow the service to recover • Pooled CAS continued to provide additional clinical support • Range of staff support and welfare measures put in place by HUC	• Escalation calls identifying most critical issues and assigning appropriate actions • Mutual Aid request answered and pooled CAS in place, allowing HUC to assign additional staff where most appropriate • Respiratory Hubs and standing down certain meetings and reporting as contributing factors to service returning to business as usual in January 23

UEC - Ambulance Response and Handover



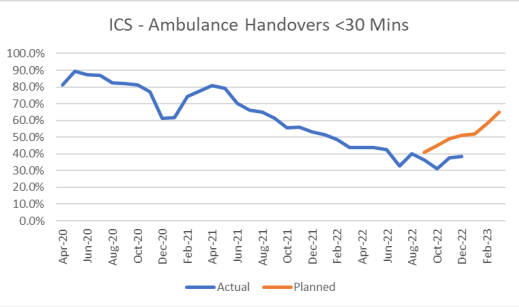


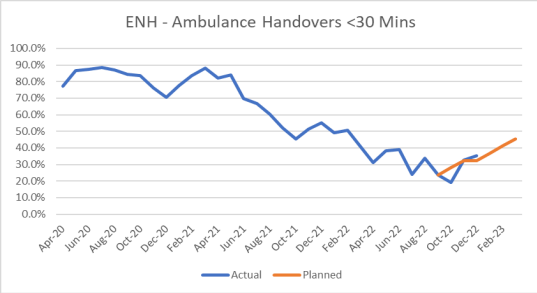


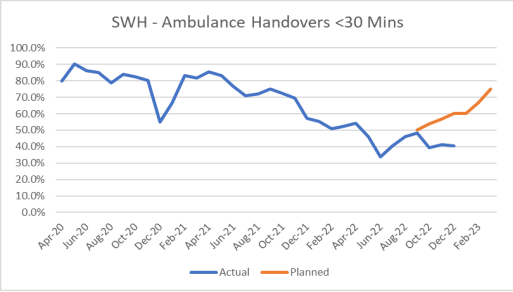


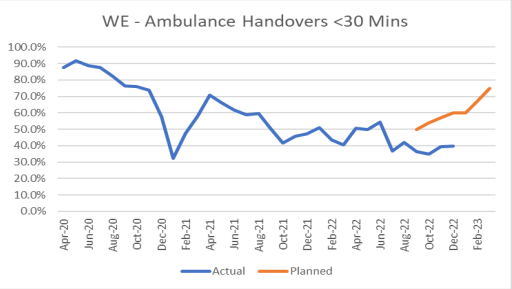
UEC - Ambulance Handover Improvement Trajectories

< 30 Minute Ambulance Handover Trajectories

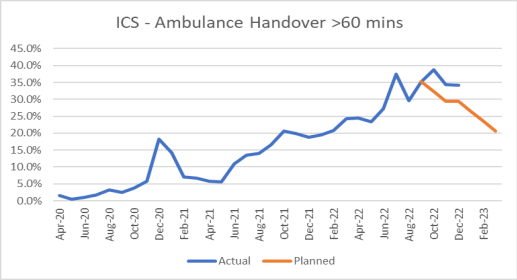


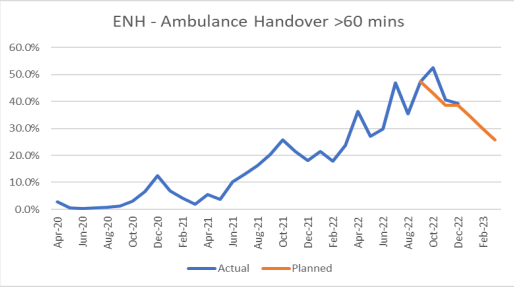


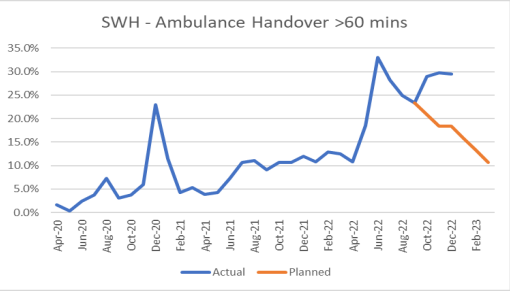


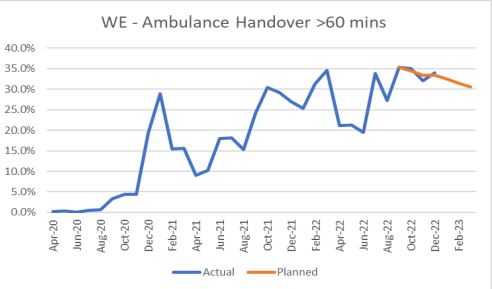


> 60 Minute Ambulance Handover Trajectories



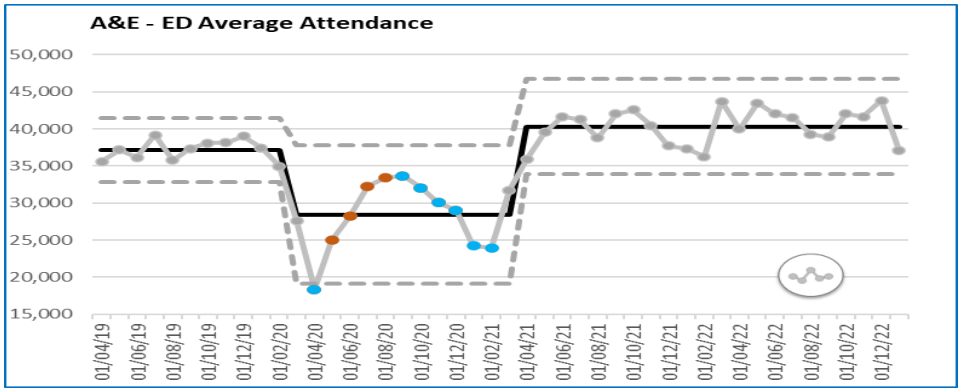


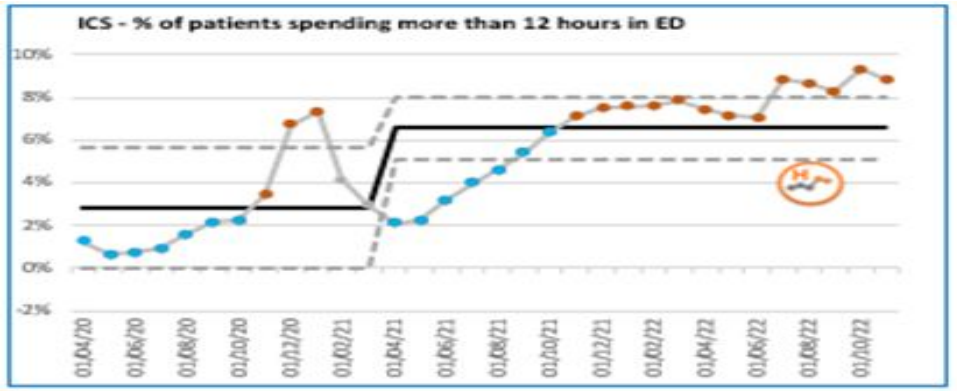


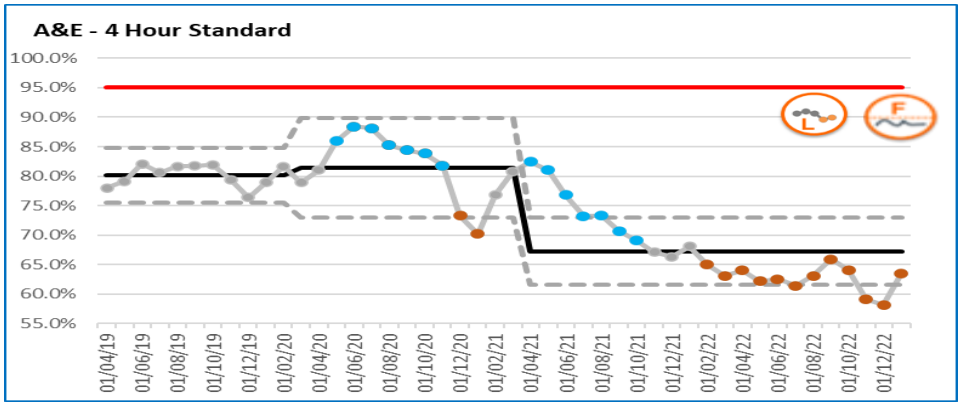


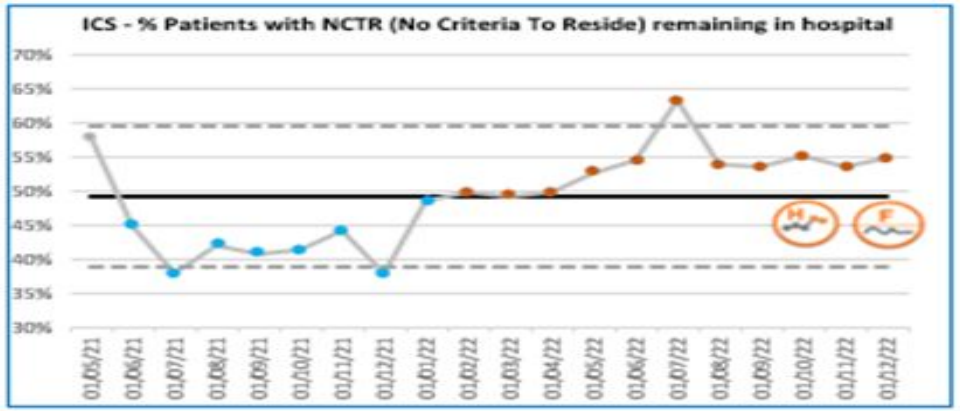
9

Urgent & Emergency Care (UEC)





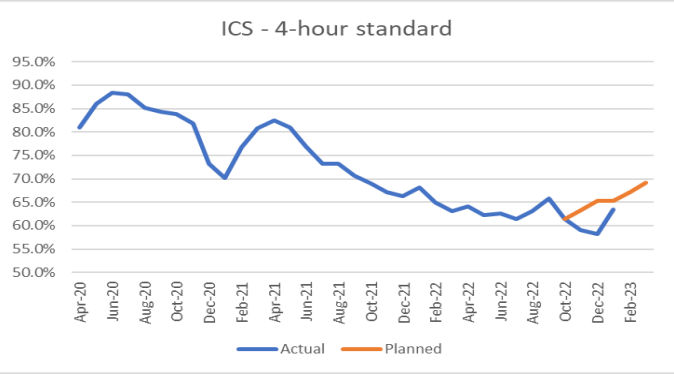




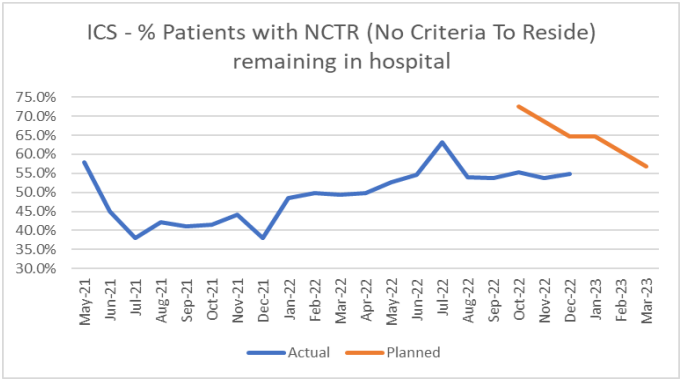
Place	Patient Journey	Area	Indicator	Target	Previous Month	Current Month	Latest Month	Month Change
WE CCG	At Hospital	Hospital flow	% Patients with NCTR (No Criteria To Reside) remaining in hospital	-	49.8%	49.7%	January	
SWH CCG	At Hospital	Hospital flow	% Patients with NCTR (No Criteria To Reside) remaining in hospital	-	54.1%	55.7%	January	
ENH CCG	At Hospital	Hospital flow	% Patients with NCTR (No Criteria To Reside) remaining in hospital	-	52.5%	52.9%	January	

Urgent & Emergency Care (UEC) Improvement Trajectories

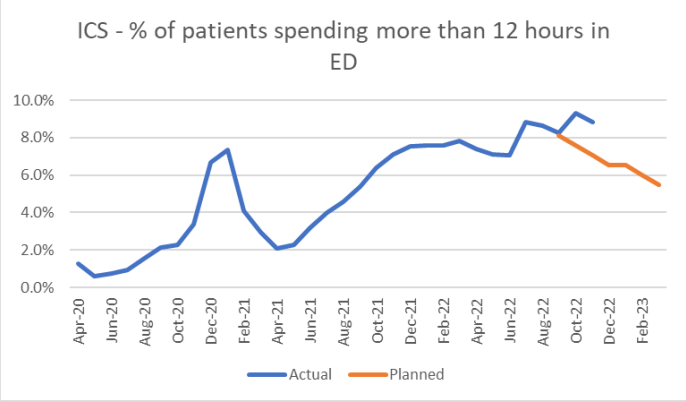
4 Hour Standard Improvement Trajectory



No Longer Meet Criteria to Reside (NLMCTR) Improvement Trajectory



12 Hours in ED Improvement Trajectory

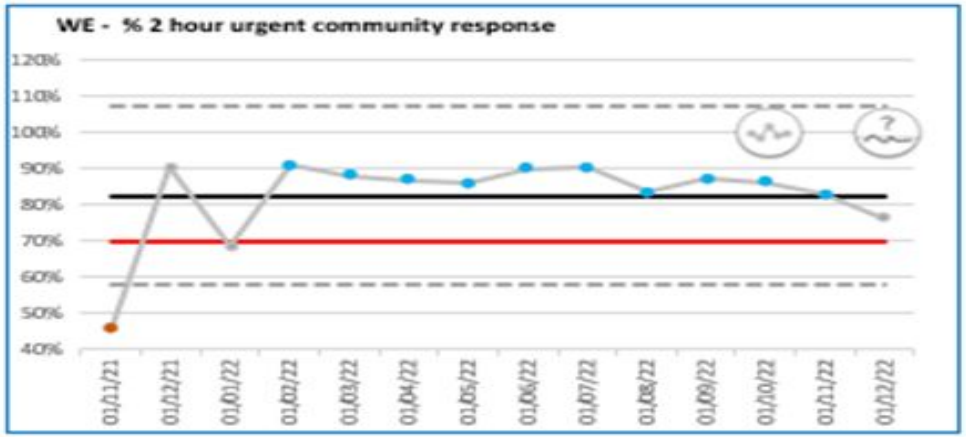


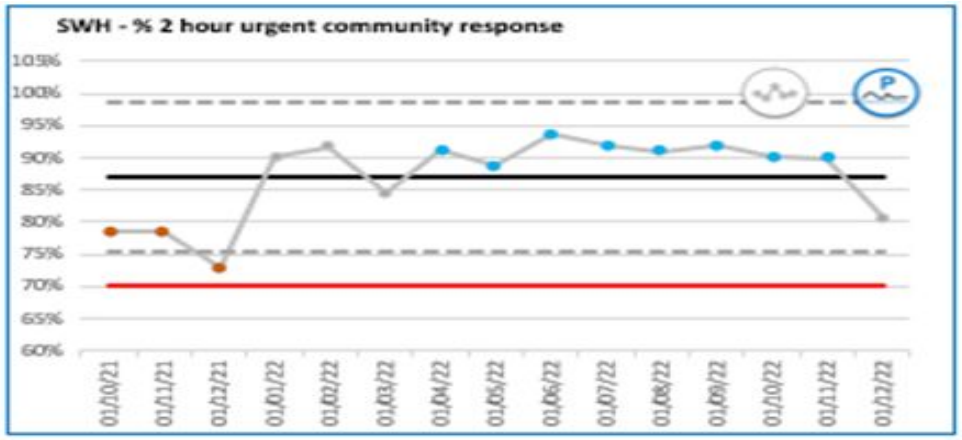
11

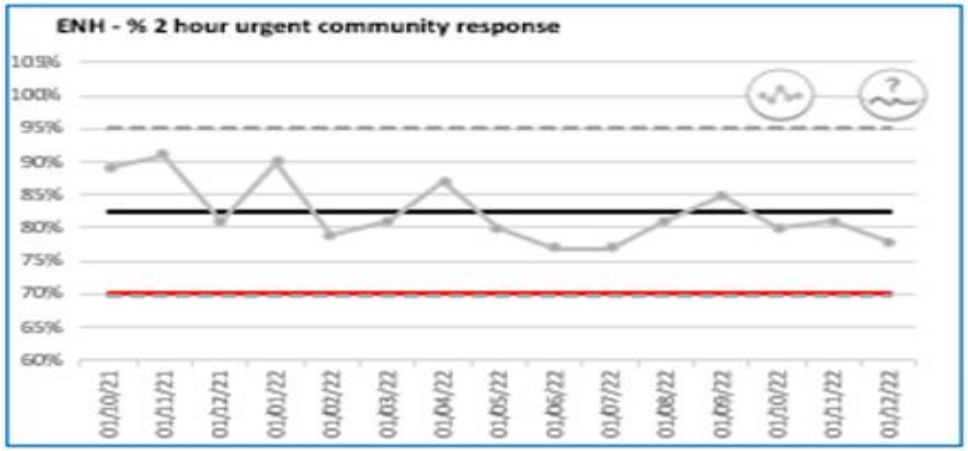
Urgent & Emergency Care (UEC)

ICB Area	What the charts tell us	Issues	Actions
ICB	• Category 2 ambulance response times deteriorated significantly in December to reach over 2 hours; • After reaching the lowest levels to date in October, performance against ambulance handover (withing 30 minutes and over 60 minutes) improved across the two months to December; • ED attendances have remained consistently above historical averages over the last 12 months coinciding with a continuing deterioration in performance against the 4hr standard, however did see a decline in Jan; • 4-hour performance remains of concern, however following further decline in December, saw an improvement in performance in January; • The percentage of patients spending more than 12 hours in the ED department remains high, although did see an improvement in the latest data available; • The percentage of patients who no longer meet the criteria to reside and who have not been discharged by 5pm have remained at significantly higher levels throughout 2022; • Above data points suggest EDs are experiencing exit block due to issues with discharge from wards; • Whilst data suggests that plans are starting to deliver small improvements in some areas, overall performance against improvement trajectories for UEC priority metrics remains off track. • Please see Appendix B, slide 35 for detail of performance by Place.	• Continued high demand for UEC services • Increased ambulance conveyance and ambulance handover delays remain high • Increased Covid/Flu admissions and acuity of patients • Workforce availability and impact of Covid/Flu on the UEC workforce • MH assessment delays and bed shortages • Strep A impact from December onwards • Acute capital build in some areas impacting on the management of current and future demand until completion in December	**Alternatives to ED/reducing attendances:** • Implementation of the HARIS/Unscheduled Care Co-ordination (which includes call before convey and access to the Stack) to provide health care professionals working within our system access to appropriate clinical support to make the best use of services across the system and to reduce delays to improve performance. This program has commenced with support to EEAST Ambulance service (East of England Ambulance service); the HARIS proof of concept week was successful in reducing ambulance conveyance and demonstrated a related improvement in 30 & 60 minute handover times. Challenges continue with establishing a sustainable model and work continues with colleagues and region to develop. **System Strategy:** • Participation in the integrated Urgent and Emergency Care (iUEC programme) supported by the National Improvement team. The ICB is one of two systems that are participating in the pilot programme. The aim of the programme is to support development of a UEC strategy, support UEC recovery and reduce overcrowding in the EDs through diagnostics based on population health needs and service redesign. • Agreed Winter Action Plan and performance improvement trajectories set against Board Assurance Framework UEC priority metrics, aligned to Action Plan. New UEC Performance report to monitor delivery against trajectories with further supporting metrics covering the 8 Winter Domains. Adult Social Care Discharge fund agreed in December. • Strengthening of ICB and Place oversight and assurance arrangements linked to local escalation surge plans, and quality and performance frameworks. • Each acute provider has its own internal UEC improvement plan. • Please see Appendix B, slide 35 for detail of actions by Place.

UEC - Urgent 2 Hour Community Response





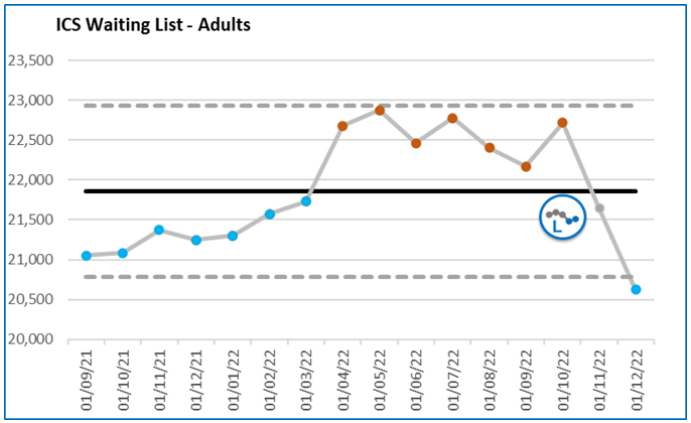


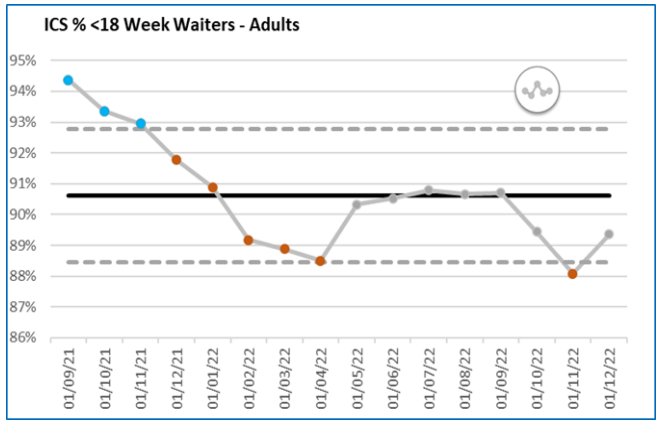
Activity	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
West Essex	289	353	468	465	428	337	451	519	387
East & North Herts	94	145	166	160	195	204	168	158	232
South & West Herts	147	142	157	162	165	124	163	139	165

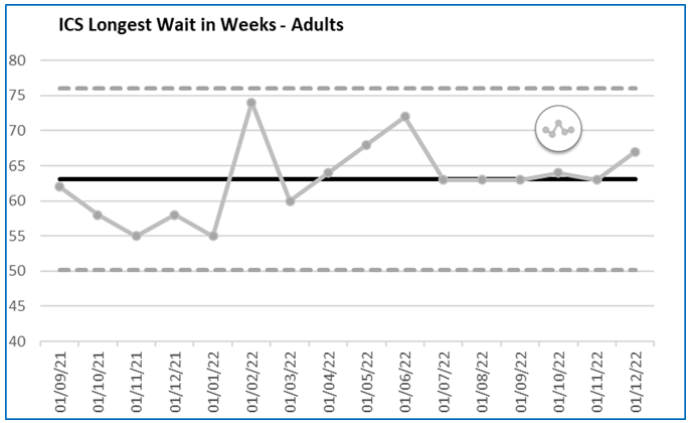
ICB Issues, escalation and next steps

- % within 2 hours performance dipped in all three places in December, but remains compliant with the expected 70% standard
- Further investigation into the activity levels across the three places has identified additional Hertfordshire activity that is reportable under the banner of Urgent Community Response
- Work is underway to capture this additional activity and we expect overall Hertfordshire activity to increase going forward

Community Waiting Times (Adults)







		Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Adults	21641	20624	↓	88.08%	89.35%	↑	63	67	↑	December

		Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	9816	9005	↓	83.58%	85.94%	↑	46	50	↑	December
ENH	AJM/Millbrook	341	313	↓	76.83%	82.43%	↑	38	37	↓	December
ENH	**All**	**10157**	**9318**	↓	**83.35%**	**85.82%**	↑	**46**	**50**	↑	**December**

		Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	CLCH	2513	2553	↑	87.43%	85.23%	↓	63	67	↑	December
SWH	Connect	5081	4903	↓	91.30%	91.72%	↑	52	50	↓	December
SWH	HCT	899	862	↓	95.55%	95.59%	↑	45	49	↑	December
SWH	AJM/Millbrook	387	351	↓	77.78%	86.04%	↑	36	35	↓	December
SWH	**All**	**8880**	**8669**	↓	**90.05%**	**89.96%**	↓	**63**	**67**	↑	**December**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT	2497	2522	↑	99.88%	100.00%	↑	20	19	↑	December
WE	EPUT - Wheelchairs	107	115	↑	98.13%	95.65%	↓	18	24	↑	December
WE	**All**	**2604**	**2637**	↑	**99.81%**	**99.81%**	↑	**20**	**24**	↑	**December**

*** NOTE: CLCH Respiratory data is not included in the above data. Will be incorporated from next month**

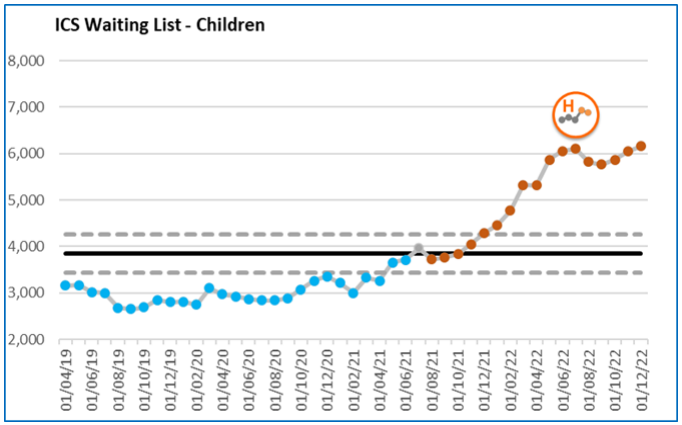
14

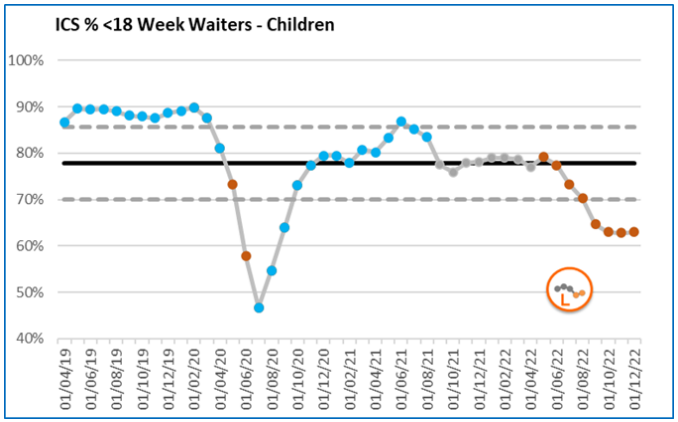
Community Waiting Times (Adults)

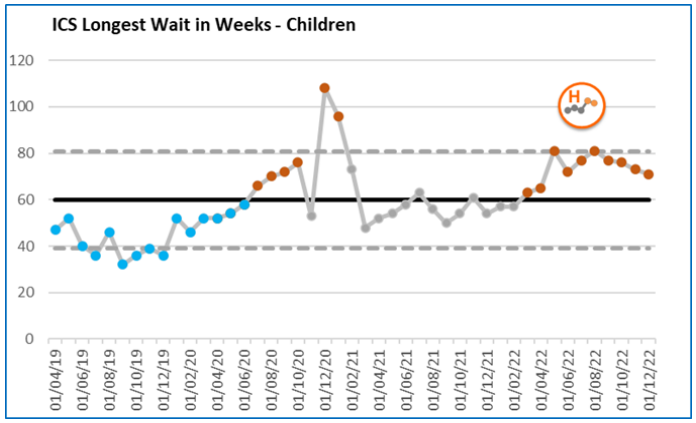
The NHS 18 week Referral to Treatment (RTT) standard only applies to consultant led services. For Adult community services this include Skin Health (ENH), Respiratory (S&W), and Podiatric Surgery (WE). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18 week target for an overall view of waiting time performance. Full detail of commissioned services in HWE is contained within Appendix D, slide 40.

ICB Area	What the charts tell us	Issues	Actions
ICB	• The total number of adults waiting on waiting lists improved significantly in both November and December. Across the System, there were 1,017 less patients waiting in December than in November • The majority of the waiting list reduction related to HCT services in East & North Herts; CLCH services in South & West Herts saw a small reduction in waiting lists; West Essex waiting lists saw a small increase of 33 patients overall • The % of patients waiting less than 18 dropped to a post-Covid low of 88.1% in November, but improved to 89.4% in December • The overall longest wait has increased from 63 to 67 weeks in December. This is in relation to an Acquired Brain Injury (ABI) patient within the Neurology Rehab service at CLCH • Consultant led 18 week RTT performance: ENH Skin Health – 85% SWH Respiratory – 65% WE Podiatric Surgery – 100%	**East & North Hertfordshire (ENH)** • Waiting times for the Neuro Service remain below target, with referrals up YTD by 11% • Waiting times for the MSK Physio Service remain below target, with reduced activity compared to 2019/20, but now with a significant reduction in the overall number of waiters • Pain Management waiting lists and contacts have increased due to demand from Long Covid **South & West Hertfordshire (SWH)** • Referrals have increased across multiple services • Respiratory holds the majority of long waiters. Consultant clinic capacity does not meet demand • Staff sickness and vacancies are improving, but there is more to do • Respiratory service holds the majority of long waiters. Demand cannot be met with current provision of consultant clinics • There are 5 x patients > 40 weeks in Neurology Rehab. These are all ABI patients waiting for Psychology input, which is a gap within the service **West Essex (WE)** • There are 5 adult Wheelchair patients who have been waiting more than 18 weeks, with a longest wait of 24 weeks • The small specialist HCT Lymphoedema service is under pressure due to an increasing caseload	**East & North Hertfordshire (ENH)** • The Neuro service has been reconfigured to increase capacity with more virtual appointments and self-management • Increasing MSK Physio capacity though estates and recruitment. Also continuing to review pathways. Initiatives working well • Pain Management service pilot of screening tool highlighted the need for clearer criterion to help patients benefit from the service **South & West Hertfordshire (SWH)** • Continue to review respiratory long waits daily, prioritising those waiting the longest • Temporary Respiratory consultant capacity via bank and alternative Hospital Trusts • Exploring insourcing Respiratory consultant sessions with external provider. Potential February start and will focus on clearing follow up backlog which will free up existing consultant clinics to focus on 1st appointments • External provider in place to support Neuro Rehab long waits. Initially 1,000 appropriate patients have been referred and seen. Further patients being explored • Division specific recruitment plan developed which includes developing videos to compliment adverts and targeting social media channels • On going discussions with two Trusts with regards to ABI patients **West Essex (WE)** • Wheelchair breaches all relate to the ordering of bespoke equipment and supplier delays. The service is still achieving 96% for RTT, and all patients have expected completion dates and suitable wheelchairs in the interim • Improving pathways for the Lymphoedema service utilising additional clinics and utilisation of telehealth to support less complex referrals

Community Waiting Times (Children)







		Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Children	6048	6159	↑	62.85%	62.98%	↑	73	71	↓	December

		Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	991	1007	↑	77.70%	80.24%	↑	73	59	↓	December
ENH	AJM/Millbrook	98	90	↓	76.53%	85.56%	↑	32	33	↑	December
ENH	**All**	**1089**	**1097**	↑	**77.59%**	**80.67%**	↑	**73**	**59**	↓	**December**

		Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	4273	4312	↑	53.59%	52.50%	↓	67	71	↑	December
SWH	AJM/Millbrook	81	81	→	83.95%	82.72%	↓	46	50	↑	December
SWH	**All**	**4354**	**4393**	↑	**54.16%**	**53.06%**	↓	**67**	**71**	↑	**December**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT - Wheelchairs	26	21	↓	100.00%	100.00%	→	17	17	→	December
WE	HCRG / Virgin	579	648	↑	98.79%	99.07%	↑	52	36	↓	December
WE	**All**	**605**	**669**	↑	**98.84%**	**99.10%**	↑	**52**	**36**	↓	**December**

*** NOTE: Community Paediatrics data for ENH Place is not currently included in the above data. Development work underway with ENHT to include in future reporting**

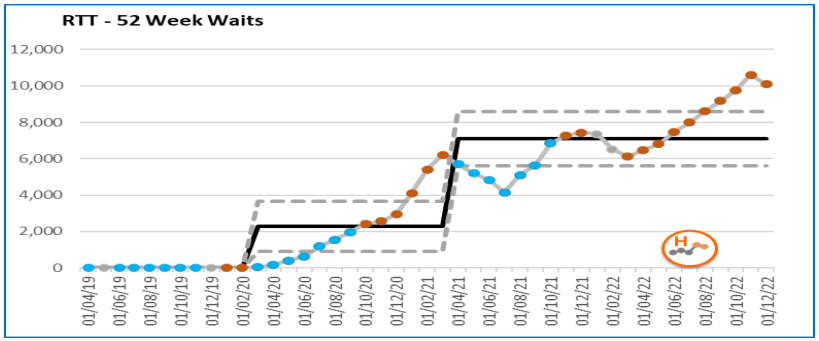
16

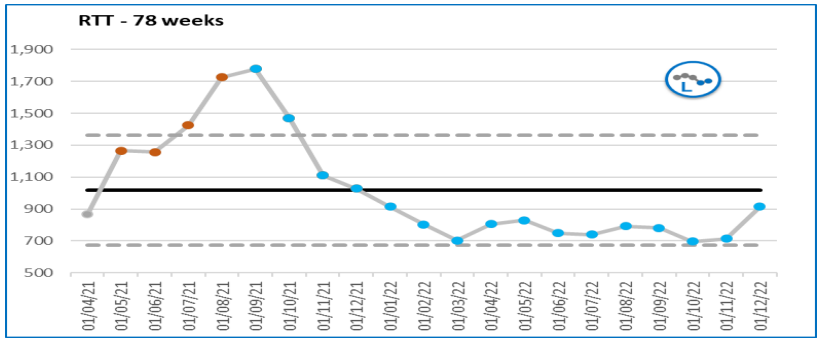
Community Waiting Times (Children)

The NHS 18 week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18 week target for an overall view of waiting time performance. Full detail of commissioned services in HWE is contained with Appendix D, slide 41.

ICB Area	What the charts tell us	Issues	Actions
ICB	• Overall, the total number of children waiting on waiting lists increased for the third consecutive month. There were 111 more children waiting in December than in November across the system • The trend of declining 18 week performance has bottomed out. There was a small improvement of 0.1% between November and December • Longest waits have reduced for the 4th consecutive month, but remain above the historic mean average • HCT services in South & West Herts remain the most challenged with 18 week performance at 52.5%, and a maximum wait of 71 weeks • Consultant led 18 week RTT performance: SWH Community Paediatrics – 42% SWH Children's Audiology – 41% ENH Community Paediatrics – 25% WE Community Paediatrics – 98%	**Hertfordshire** • Waiting times across Hertfordshire for Children's Therapies (OT, Speech & Language and Physiotherapy) are below target • Waiting times in the SWH HCT Community Paediatrics service remains challenged. Referrals have increased by 27%, although service productivity has also improved - up by 31% • The Paediatric Audiology service in SWH remains challenged, with only 42% being seen within the target wait time **West Essex (WE)** • There are no particular issues of concern to report for December. There are only 6 patients exceeding 18 weeks across all services – all within Community Paediatrics	**Hertfordshire** • Children's Therapies – increasing capacity through recruitment, waiting list initiatives and outsourcing • Working closely with commissioners on wider improvements across Special Education Needs (SEN) / Education, Health & Care Plan (EHCP) processes • Community Paediatrics in SWH is receiving non-recurrent additional investment, increasing workforce capacity and introducing new specialist nursing posts. Risk remains on recruitment to these roles. Transformation Programme group established to take forward service redesign • Paediatric Audiology in SWH is focusing on higher priority appointments, especially follow up appointments. Signposting to interim advice whilst awaiting assessment. Analysis underway for workforce business case, as capacity is not currently sufficient to meet demand **West Essex (WE)** • WE Community Paediatrics Business Case has now been received from HCRG and is under review. Commissioners have raised a number of queries with the provider and local negotiation is continuing prior to proceeding to formal governance.

Planned Care – 52 & 78 Week Breaches

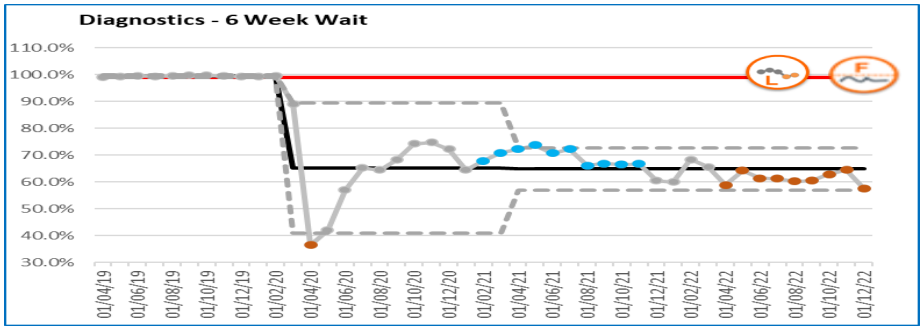


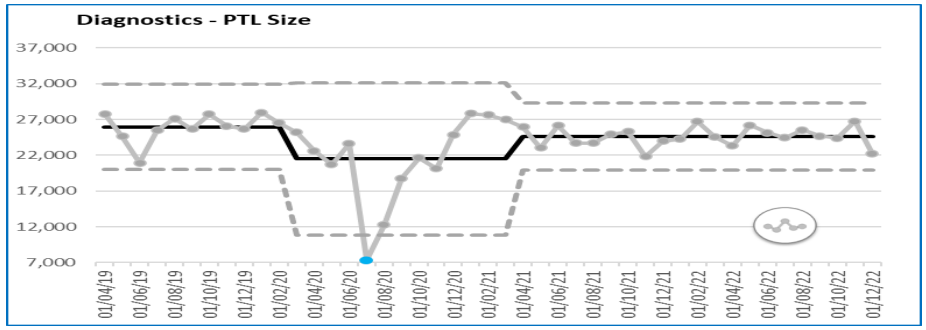


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	0	231	218	288	378	434	399	325	283	260	243	190	223	266	281	296	248	208	141	108	157
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	353	389	364	388	407	362	271	189	169	162	140	111	144	155	143	133	137	116	92	69	69
EAST AND NORTH HERTFORDSHIRE NHS TRUST	516	646	674	748	940	983	800	598	577	492	420	401	439	408	324	312	407	458	464	548	689

ICB Area	What the charts tell us	Issues	Actions	Mitigation
HWE	• No capacity breaches over 104 weeks • Dec has increased number of patients >78 weeks however numbers have fluctuated across last 6 months and improvements have been seen in January • The number of patients waiting over 52 weeks decreased slightly in Dec ending an 8 month upward trend, however remain high and of concern.	• Whilst there has been a reduction of longest waiting patients, not enough activity is being delivered to manage backlog effectively • 78 wks not projected to deliver '0' by March 23 • High referral volumes in early 21/22 now reaching their 52 week wait • UEC pressures impacting operating & bed capacity • Diagnostic waiting times • Staffing remains a challenge, particularly around anaesthetics • Lack of WLI additional capacity due to rate change • Trauma and Orthopaedics and Community Paediatrics remain the main areas of pressure for long waiters	**Management of waiting lists:** • System focus on reducing number of patients waiting >78 weeks, with regional and national oversight; • WHTHT has been de-escalated from Tier 1 to Tier 2 for 78 weeks in February 2023; • PAH & WHTHT are on track to meet the '0' 78 week target by March '23 with ENHT also ahead of trajectory; • Demand, capacity & recovery plans in place with weekly specialty trajectories to monitor 78 weeks; • Weekly KLOEs in place with NHSEI to track 78 week position; • Fortnightly performance meetings with NHSEI support; • Validation and robust PTL management in place. **Increasing Capacity and Improving productivity:** • Pro-active identification of pressured specialties with mutual aid sought vial local, regional & national processes; • All providers signed up to Digital Mutual Aid System (DMAS) and have completed training; • Maximising use of ISP capacity and WLIs where possible • Community Paediatrics escalated to national level for mutual aid to support recovery; • Business case completed and has been through ICB governance for a system high volume low complexity elective hub to add elective capacity from 24/25. It has been submitted to NHSE; • Mapping of elective programme in the UEC Winter Plan; • Theatre Utilisation Programmes in place including an ICB wide programme; • Anaesthetist recruitment	• Actions delivering overall reductions in long waiting patients • National emphasis on prioritising patients in order of clinical need resulting in longer waits for routine patients • Clinical harm reviews and regular patient contact to manage patient safety and experience.

Planned Care – Diagnostics





ICB Area	What the charts tell us	Issues	Actions	Mitigation
HWEICB	• Patients waiting over 6 weeks increased in December, most noticeably in ENHT • Demand is increasing - a mix of routine, Cancer and UEC. • WHHT Imaging is performing well, with the exception of DEXA. This should start to improve in 2023 • The PAH position slipped in December, most notably in MRI, NOUS and Endoscopy, but is now improving • ENHT is performing well in Audiology and Cystoscopy, but Imaging is challenged. DEXA has started at the CDC	• Workforce is the key challenge, particularly for DEXA, Audiology, NOUS and ECHO • Urgent/Cancer referrals have increased and are being reviewed for appropriateness. Initial work indicates that they are • There is no additional revenue funding available for mobile units • ENHT estates and staffing issues for mobilising the CDC DEXA service. Activity has now commenced. • Time for onboarding and training of international Radiographer recruits at ENHT and PAH	• New QEII CDC – over 10k new investigations undertaken. DEXA has now commenced. Additional CDC modalities will be live from April 2023 (Respiratory and Holter monitoring) • WHHT investigating insourcing and mobile DEXA options and will share resources with ENHT. Imaging Network also supporting with options to improve the DEXA position • iRefer CDS has been implemented at PAH. Early signs indicate that it is having a positive impact • WHHT is working through internal governance processes to offer ENHT mutual aid for MRI • System-wide diagnostic improvement plan in place. Includes recovery trajectories for all challenged modalities. All modalities are expected to be DMO1 compliant by March 23 with exception of following challenged areas with longer recovery trajectories: Audiology, Non-Obstetric Ultra Sound, MRI (ENHT), ECHO (WHHT) and DEXA (WHHT and ENHT) • Audiology system wide review. Challenges are at PAH and WHTH. Initial actions are to review the ENHT service for learning, analysis of benchmarking data, and looking at mutual aid for PAH. • CDC mobilisation commenced at WHHT and PAH. WHHT expecting to be live from March 2024; PAH TBC, but looking at what could be bought forward if revenue funding received • ENHT secured funding as part of the diagnostic focus month in March for backlog improvement • PAH have received 1 months funding for additional NOUS activity in March 2023 • WHHT and PAH funding from NHSE to replace a number of x-ray rooms across their CDC sites	• Continued use of insourcing / outsourcing • WHHT flexing operational hours for each modality • PAH MRI mobile unit on an ad-hoc basis to try and manage waiting times • Ambitions for the 2023/24 operational plan build on the existing work around increasing activity levels and decreasing waiting times

Planned Care – Theatre Utilisation

March 22

Theatres	ENH	PAH	W Herts
Utilisation - Capped	77%	62%	68%
Utilisation - Uncapped	80%	65%	77%
Average late starts (Minutes)	30	48	50
Average inter case downtime (minutes)	14	18	28
Average early finish (Minutes)	81	109	80
Average unplanned extensions (Minutes	30	61	96
Average cases per 4 hour session	2.6	1.8	2
BADS Day Case	79%	60%	71%

Source: Model Health System, NHSE & I

October 22

Theatres	ENH	PAH	W Herts
Utilisation - Capped	83%	69%	59%
Utilisation - Uncapped	85%	73%	62%
Average late starts (Minutes)	29	61	38
Average inter case downtime (minutes)	15	16	22
Average early finish (Minutes)	57	76	128
Average unplanned extensions (Minutes	32	51	125
Average cases per 4 hour session	2.5	1.8	1.7
BADS Day Case	83%	77%	67%

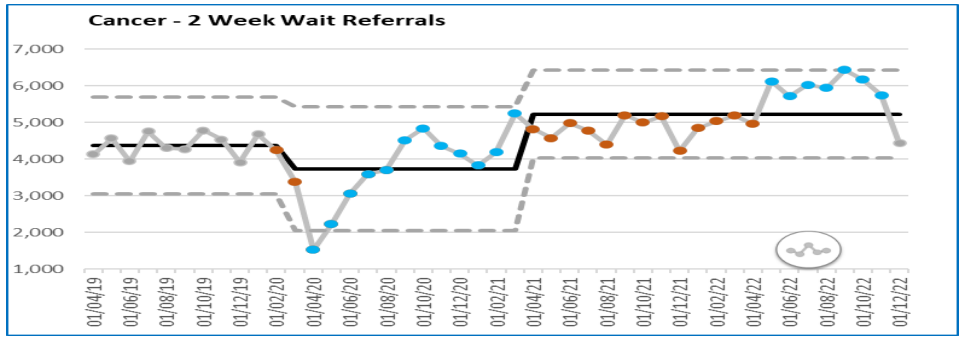
Source: Model Health System, NHSE (9/10/22)

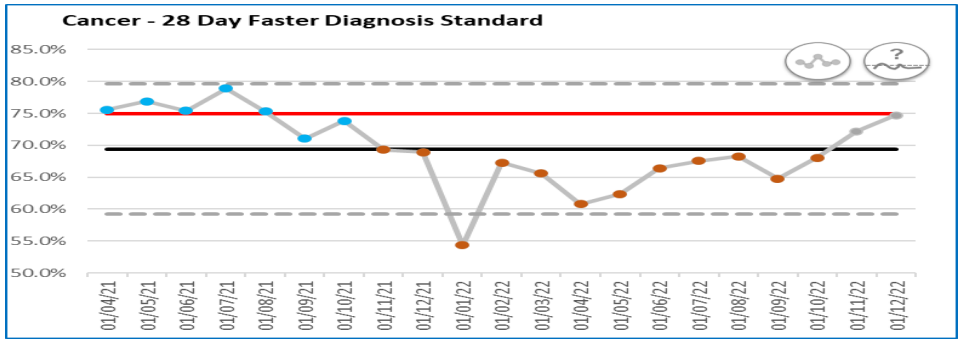
Worst quartile · Best Quartile

ICB Area	What the charts tell us	Issues	Actions
HWEICB	• No further data updates on October 22; • Comparison of Model Hospital theatre utilisation data from March 22 to October 22, rag rated against quartile performance; • Both capped and uncapped utilisation has improved at ENHT and PAH but declined at WHTHT; • BADs Day Case Rates have improved at ENHT and PAH but declined at WHTHT.	• All Trusts need to further improve their theatre capped touch time utilisation to reach the 85% target • All Trusts need to further improve their BADs Day Case Rates to reach the 85% target • Self assessment of current status will identify specific issues and actions to form delivery plan	GIRFT High Value Low Complexity Targets (HVLC): 1. Theatres Capped Touch time Utilisation = 85% 2. Theatres Capped Touch time Utilisation for HVLC = 85% 3. BADS Day Case Rates = 85% • A system wide theatre efficiency and productivity group has been established which first met in December 2022; • The group will pull together the work programmes of each of the three providers which are already established; • The three focus points will be; delivery plan to improve compliance to the 85% target, a self assessment of the current status, and looking at right procedure, right place.

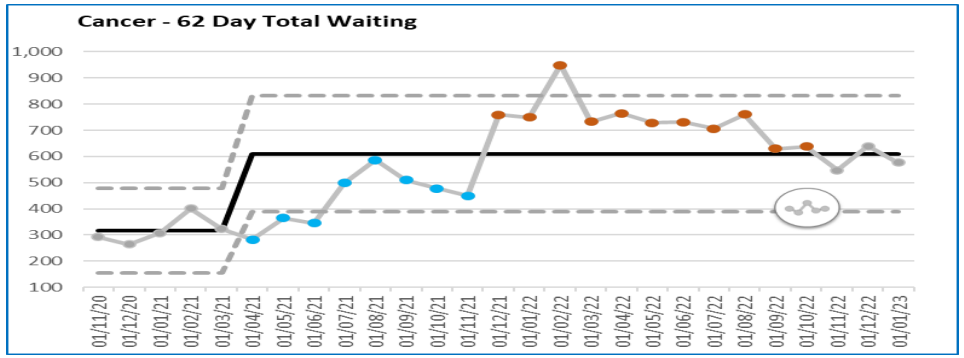
20

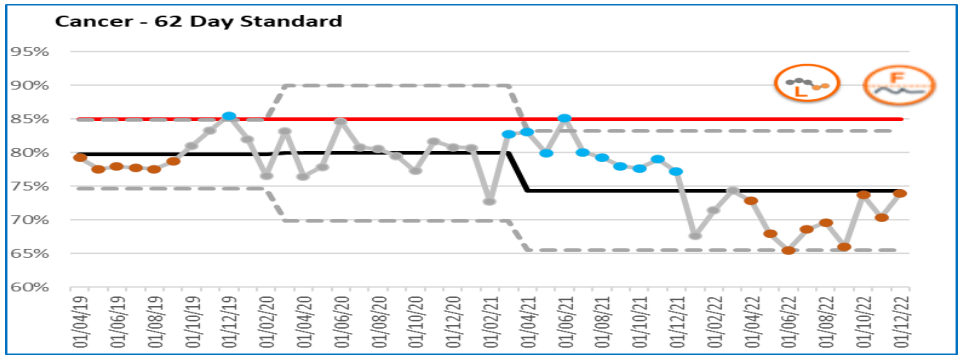
Cancer





	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
EAST AND NORTH HERTFORDSHIRE NHS TRUST	72.1%	73.6%	76.2%	76.7%	72.0%	71.8%	76.5%	74.8%	74.1%	64.2%	72.9%	74.8%	68.0%	64.2%	70.6%	71.7%	72.6%	69.7%	73.9%	73.7%	77.4%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	81.3%	79.8%	81.4%	82.1%	77.8%	77.2%	77.7%	71.9%	64.7%	47.0%	59.2%	54.6%	51.3%	57.7%	55.6%	60.3%	60.2%	57.8%	63.2%	71.9%	72.7%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	72.5%	74.6%	66.8%	77.1%	73.9%	62.9%	65.1%	60.6%	66.8%	50.9%	69.4%	69.2%	64.1%	65.9%	74.3%	72.3%	72.8%	68.5%	70.4%	73.7%	74.9%
ICS	75.6%	76.9%	75.4%	78.0%	75.3%	71.1%	73.8%	69.3%	68.8%	54.4%	67.3%	65.6%	60.8%	62.4%	66.4%	67.5%	68.5%	64.8%	68.0%	72.2%	74.7%





	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	73	76	96	105	79	83	109	88	132	179	130	128	129	331	347	374	307	261	297	297	277	270	257	233	195	191	184
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	129	118	200	187	127	107	141	161	212	224	201	190	127	175	176	303	194	182	156	128	125	162	152	163	149	193	182
EAST AND NORTH HERTFORDSHIRE NHS TRUST	90	70	120	106	117	92	114	96	155	184	178	160	193	253	226	272	232	322	275	306	304	329	221	242	203	256	211

Cancer

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• 2 ww cancer referrals reduced for the last 3 months and were at the lower end of the control range in December • 28d FDS performance has improved for the last 3 months and fell just short of the 75% national ambition in December at 74.7% • Recovery of the 62 day backlog stalled over the festive period, but returned to an improving position in January; further work required to meet March 23 ambition of 427 – see slide 22	• Continued high referral levels • Cancer management, tracking and coding capacity • Urology and Lower GI capacity and workforce – other tumour sites are achieving, or close to plan • 2 week wait Tele-Dermatology service launch on hold due to lack of provider interest	• Demand & capacity work completed in Urology indicates significant workforce increase is required. Business planning underway & discussions with CA re. potential funding • Dedicated biopsy clinics taking place through February / March • Tele-Dermatology plans being reassessed for alternative models of provision • Breast pain clinic pilot went live in early Feb. Minimal patients but will expand • Super PTL days is in place to target booking and validation on a service by service basis	• System support and oversight in place with bi-weekly meetings • Weekly Key Lines of Enquiry (KLOE) process in place with Cancer Alliance • Cancer Harm Review process in place
South West Herts / WHTHT		• Breast symptomatic performance remains non compliant at 67% on account of the backlog and continued increase in demand, however this is a marked improvement on the November 2022 position (38%) ; • Although improving, 62 day performance remains non-compliant: increase in demand, slow diagnostic pathways, delays for some OPA appointments, delays in partner providers & delay in availability of letters all contributing factors; • The number of patients >104 days continues to decrease however slow diagnostics and some difficulty with patient engagement (making contact and holiday season) are slowing the whole pathway including those waiting over 104 days; • The number of patients >62 days is decreasing but at a slower rate than those over 104 days.	• The breast service is actively seeking ways to increase capacity - provision of ad hoc clinics, recruitment of locum breast consultant, outsourcing, switching routine OPA slots to 2ww slots. • Work continues to develop a community based Breast Pain Only clinic. • All efforts to regain the 2ww position will contribute to improving the FDS position • All services have actions to improve the management of their pathways as part of the Trust's improvement plan. • Capacity and demand modelling being completed for all specialties based on FDS pathways. • Patients are tracked bi weekly and escalations sent to services twice/ week. • Performance reviewed in weekly meetings. • All services are working on improvements. • Long Waiters Reviews now beginning at 49 days across all specialties. • Patient-level scrutiny for all long waiters during the weekly Cancer Long Waiters' meeting. • The principles of the "spotlight on cancer" weeks continue in many services. • Work starting to enable services to have a validated PTL to prevent tip-ins (days 49 to 62)	• Although no longer in any tier for cancer, 62 day backlog scrutinised in fortnightly Tier One and oversight meetings • All patients remain on eRS until booked when they are entered onto the Cancer PTL where they are tracked. • Clinical harm reviews for those who have a cancer diagnosis and waited >28 days for a 2WW appointment, patients who are treated after Day 62 and patients found to have cancer after 104 days. • Clinical reviews are requested by MDT trackers as they track patients and escalated as necessary
East & North Herts / ENHT		• Improvements in 62 day backlog and return to meet 62 day first performance standard in Dec; • Breast Radiology continues to face issues with capacity and staffing, likely to continue to impact 62-day cancer; • Staffing shortages remain an issue for the Anaesthetic department; • Challenges with late referrals to ENHT as a tertiary centre impacting PTL waits >62 days	• Trust has been moved from Tier 1 to Tier 2 based on progress in reducing 62-day backlog • Tier 1 Action plan remains in place with Breast, Skin, Upper and Lower Gastrointestinal, MDT team, Histopathology and Radiology actions to improve MDT follow-up, reporting and more timely communication of diagnosis and next steps, particularly for patients who do not have cancer; • Deep dives for tumour sites continue; • Additional scrutiny and support leading to improved performance; • Timed pathways now in place for all Tumour sites to improve and sustain 62-day standard and deliver the Faster Diagnosis Standard performance. • Continue to analyse breaches by Tumour Site to identify issues & resolve pathway delays.	• Weekly Key Lines of Enquiry (KLOE) process in place with Cancer Alliance • Fortnightly Tier 2 performance meetings and review of recovery • Robust weekly PTL management in place; clinical and operational review of patients waiting >62 and 104 days with clinical harm reviews in place

Performance v. 22/23 Operational Plans

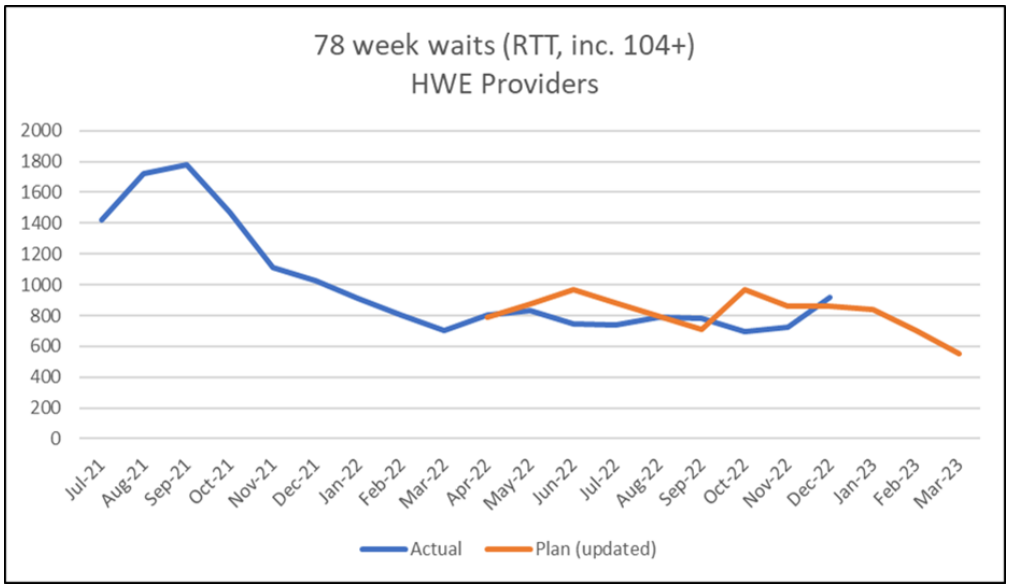
Herts and West Essex Providers (please see Appendix C, slide 37 for performance by Place)

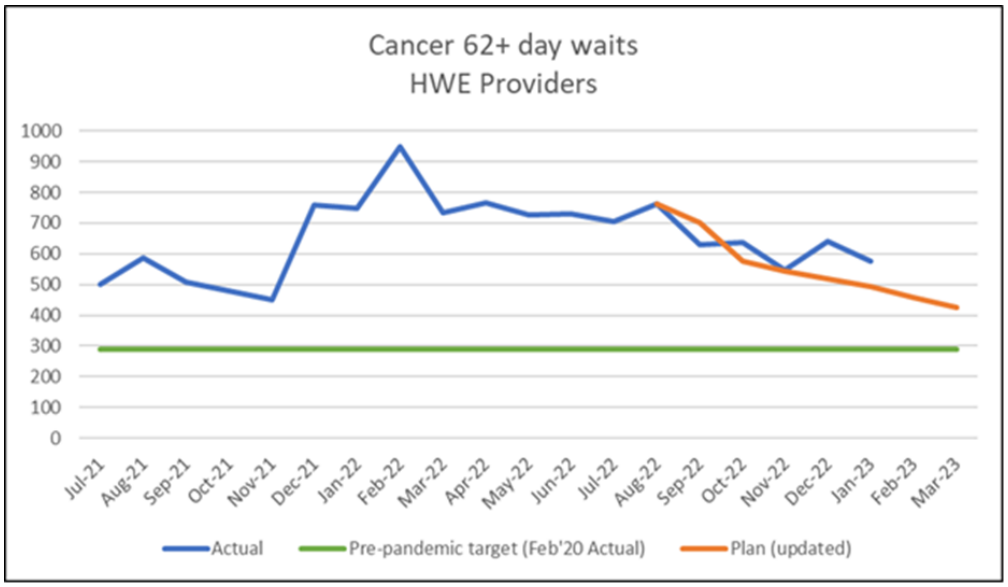
Baseline	22/23 Activity Plan	22/23 M1-9 Activity Plan	Area	Target		April	May	June	July	August	September	October	November	December	Total	Target Achievement @ M9
246,604	330,131	238,432	Activity	10% elective activity increase (19/20 levels RTT pathway)	Plan	16,815	19,497	22,586	30,620	29,143	30,317	30,467	31,091	27,896	**238,432**	-7%
	+34%				Actual	16,815	20,581	19,866	18,336	18,833	20,939	21,207	23,267	17,409	**177,253**	
					Variance	0	1,084	-2,720	-12,284	-10,310	-9,378	-9,260	-7,824	-10,487	**-61,179**	
N/A	0	2	Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)	Actual	124	77	35	15	9	5	4	5	3	**3**	Trending down
N/A	0	426		Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)	Actual	806	829	748	741	792	782	697	725	915	**915**	Increasing
6,109	6480	6945		52 week waits trending down across 22/23	Actual	6484	6804	7472	7988	8615	9173	9744	10611	10095	**10095**	Trending up
956,620	890,984	677,879	Outpatients	25% reduction in outpatient follow-ups by 2023	Plan	72,089	76,682	73,718	82,239	74,852	75,573	77,741	76,117	68,868	**677,879**	-7%
	-7%				Actual	70,256	79,357	72,553	71,481	72,114	72,744	72,809	80,399	72,722	**664,435**	
					Variance	-1,833	2,675	-1,165	-10,758	-2,738	-2,829	-4,932	4,282	3,854	**-13,444**	
N/A	3.1%	2.2%		5% of outpatients moved or discharged to PIFU	Actual	0.7%	0.9%	0.9%	0.7%	0.8%	0.8%	0.8%	0.8%	0.8%	**0.8%**	0.8%
8%	25%	26%		25% of consultations via video/telephone	Actual	23%	22%	23%	23%	22%	23%	23%	24%	24%	**23%**	23%
N/A				16 specialist advice requests per 100 outpatient firsts	Actual	25	25	25	27	27	25	25	25	23	**25**	25
417,182	448,818	337,892	Diagnostics	20% increase in diagnostic capacity against 19/20 levels	Plan	33,749	36,708	35,018	39,879	37,842	38,186	39,654	38,376	37,551	**336,963**	-16%
	+8%				Actual	30,029	33,868	31,968	32,034	33,068	32,603	32,543	35,116	29,716	**261,993**	
					Variance	-3,720	-2,840	-3,050	-7,845	-4,774	-5,583	-7,111	-3,260	-7,835	**-74,970**	
289	267	366	Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels	Actual	765	728	731	706	761	630	638	547	640	**640**	Trending down
69%	69%	77%		Reduction in missed 28 day cancer decisions *(Measure is % decisions delivered in 28 days or less)*	Actual	61%	62%	66%	68%	68%	65%	68%	72%	75%	**66%**	% within 28 days increase at M8

ICB Issues and escalations

- Activity significantly off planned levels for both elective and diagnostics (as seen nationally);
- Revised recovery trajectories agreed with NHSE/I and planning submissions updated;
- Good delivery against patients waiting over 104 weeks, with remaining patients a result of choice;
- Patients waiting over 78 weeks increased in December; whilst trajectory is not forecast to deliver zero by March 23, activity remains largely to plan – see next slide;
- 52 week waits remain high and are a significant area of concern;
- Out Patient programmes of work remain largely on track however percentage of patients moved or discharged to PIFU remains low;
- Cancer backlogs have reduced, however further work required to reduce to the revised March 23 ambition of 427 – see next slide.

Performance v. 22/23 Operational Plans

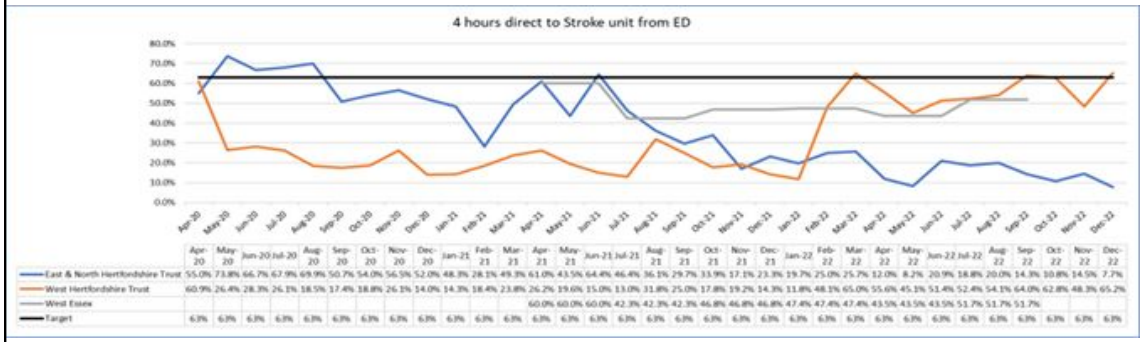


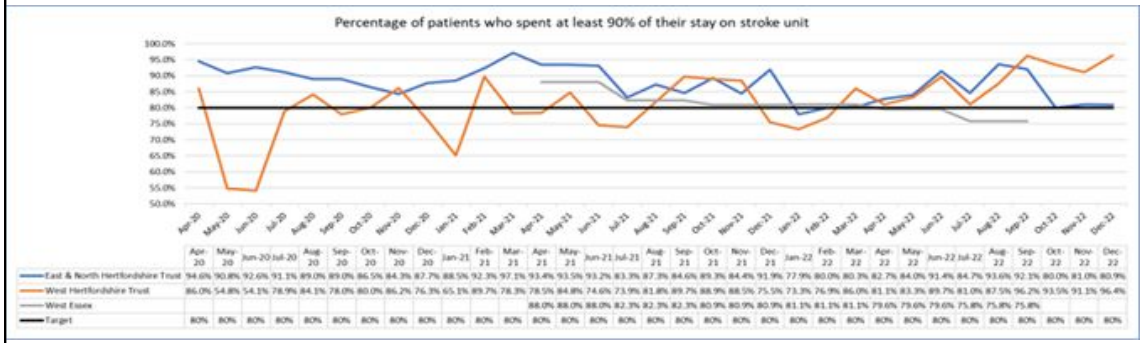


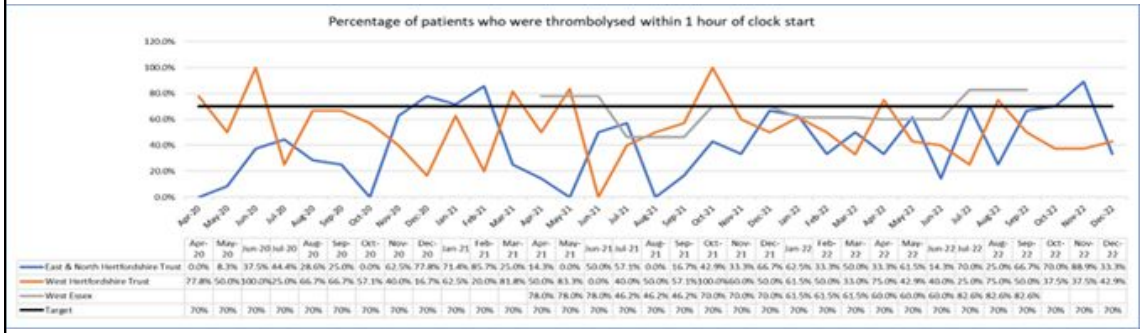
ICB Issues and escalations

- 78 week activity remains largely to revised plan, however the number of patients did increase in December. As at 12th February, the unvalidated 78 week backlog had declined to 785;
- Potential risk to 78 week recovery trajectory from Industrial Action;
- Cancer 62 day backlogs improved in January after seeing an increase in December, however remain behind Plan. As at 12th February, the unvalidated 62 day backlog had declined further to 508; delivery of 62 day backlog trajectory in March 23 is at potential risk.

Stroke







ICB Issues, escalation and next steps

West Essex: Barking, Havering and Redbridge Trust (BHRT) is the main provider of Stroke for West Essex patients, reported quarterly via the national SSNAP database. Q3 data is yet to be published.

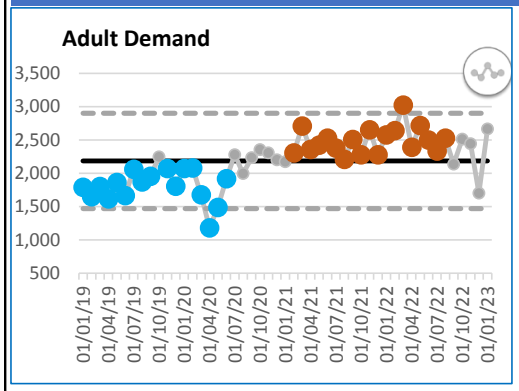
- West Essex Stakeholder Programme Group overseeing 23/24 work programme including:
  - Pathway for 6 month reviews and closer working with patients, GPs and carers
  - Stroke Passport development by Stroke Association – presentation to March meeting
  - Pre-hospital Stroke Video Assessment pilot. Ambulance crews suspecting a stroke can call a consultant directly via ipad to support the most appropriate / timely next steps
- T&F group established to review the pathway between PAH and Queens. Specific concerns re staffing to meet HASU standards, and increased DNAs from patient reluctance to travel
- Stroke Association contract extended to March 23. Business case discussed and agreed to extend for a further 2 years to align with Hertfordshire arrangements
- ICB Squire bid successful for CLCH and HCT nominated staff to complete a gap analysis of community across the ICB. Outcomes to be reported in April 2023
- Catalyst funding bid successful to pilot the implementation of vocational rehab, EPUT are the leading provider to be provided for all the community providers across the ICB. Starting in April

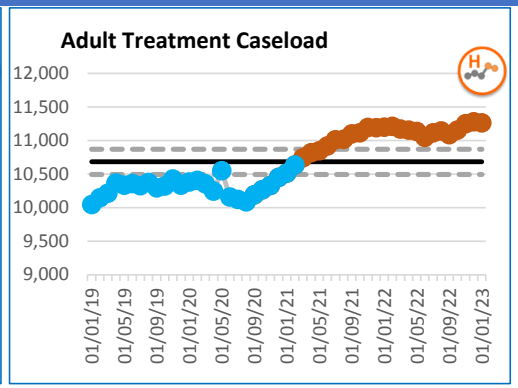
Herts: WHTHT SSNAP performance (July–Sept 22) returned to an A rating although the Team report this doesn't reflect how difficult it has been to achieve. ENHT remains at a D rating. Performance continues to meet standard for the percentage of patients who spent at least 90% of their stay on a stroke unit, at 96% in WHTHT and 80% at ENHT in December. Performance remains below standard against the percentage of patients who were thrombolysed within 1 hour of clock start with WHTHT achieving 43% in December (Local target 50%) and ENHT 33%. A review and validation of the reasons patients were not thrombolysed within the one hour window has been undertaken which showed clinical factors and complexity on presentation. As seen nationally, performance remains below standard for 4 hours direct to stroke unit from ED at both Trusts, however WHTHT have seen a slight improvement in performance at 65% in Dec; ENHT saw a further decline in performance to 7.7% in Dec due to Trust wide capacity issues and a high number of medical outliers and ambulance handover delays. Continued assurance that patients receive stroke consultant input and specific recommendations for their care while waiting for admission to stroke unit. Current pressures on the system as a whole, present increased challenges around patient flow and bed occupancy. Workforce remains a challenge, especially within the OT and SLT workforce. ESD performance also impacted by increased referrals and workforce issues.

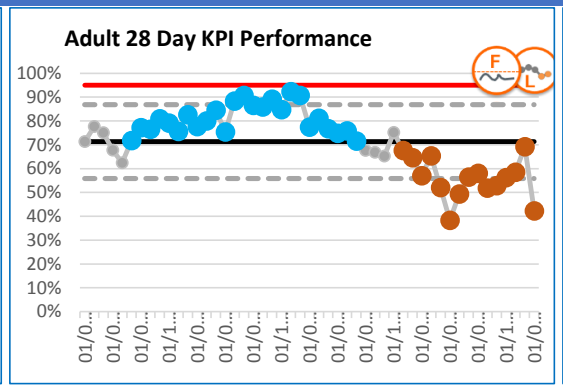
Next Steps

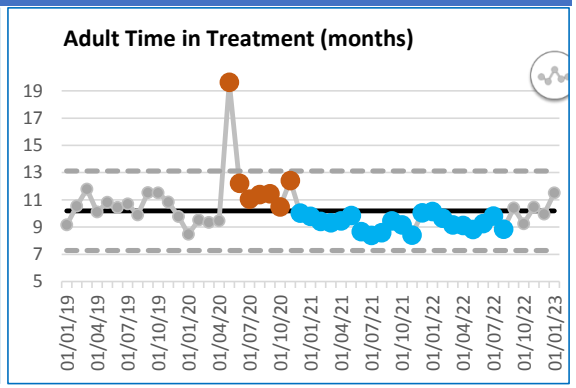
- WHTHT maintaining ring fenced beds on the HASU and a ring-fenced side room for patients requiring thrombolysis whilst awaiting swab results. ENHT have ringfenced Stroke bed capacity increasing it from 3 to 4 beds; escalation beds (4) available within Stroke to support capacity when required
- Clinical teams at WHTHT agreed to share 'good practice' around SSNAP Performance with E&NHT
- ENHT Stroke team working with ED and external ICS working group on pathway review to support Stroke pathway from admission to discharge. Ongoing meetings between Stroke team and Non-exec to support Stroke priorities.

Mental Health – Adult Services



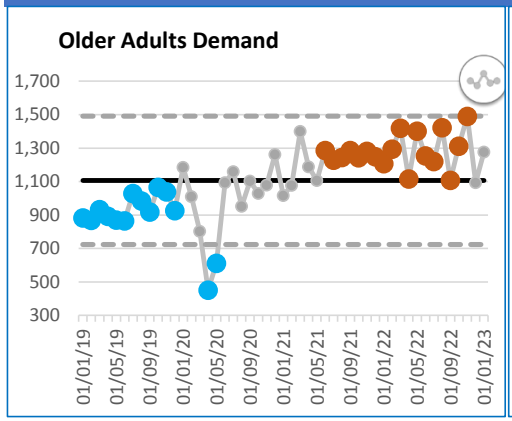


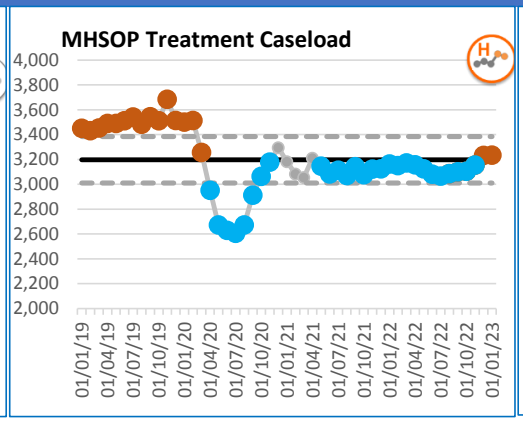


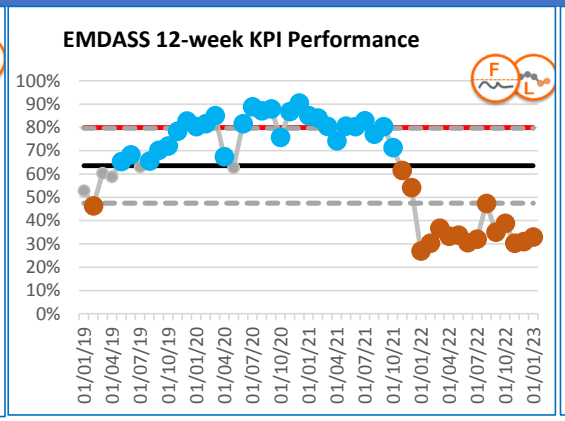


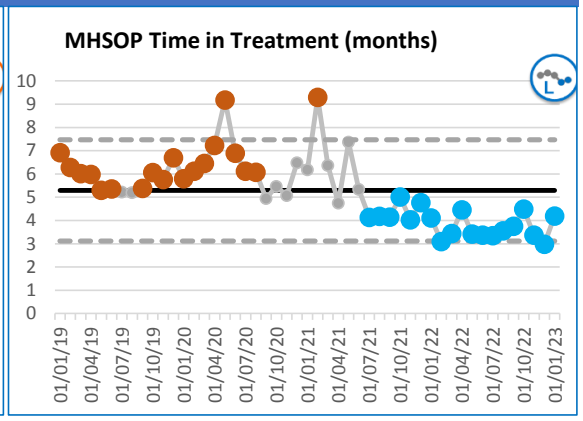
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Adult Community Mental Health Services	Increased referral demand has flatlined in the last quarter but remains above Pre-Covid levels. There are c800 more service users in treatment now than there were at the start of the pandemic. The time it takes from referral to assessment has increased in line with high referral volumes and caseloads.	Sustained high demand has resulted in a waiting list for initial assessments in HPFT, with high levels of vacancies in some teams where recruitment is particularly challenging. Reduction in wait times; 95% of overall services users are seen within 59 days in HPFT. However, nearly all service users in EPUT are seen within 28 days.	Agency staff recruited, who are currently undertaking additional assessments every week. Additional administrative support extended to community mental health teams Commissioned external process efficiency consultant (LEAN) to optimise current processes in HPFT. Out of hours clinics to provide extra capacity from substantive staff and make access easier for service users	Flow continues across the adult community pathways. Continuing to develop flow through improvement of the service model. Community Transformation continues to see more service users in primary care. Recovery for performance is expected at the end of Q4.

Mental Health – Older Adults Services



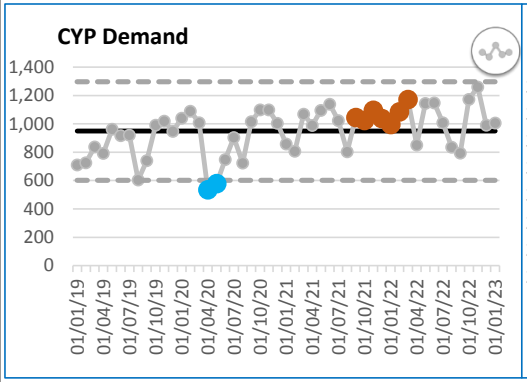


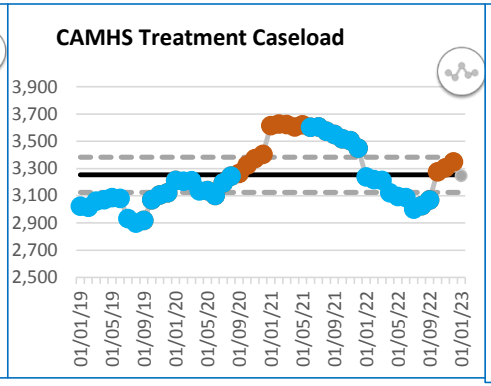


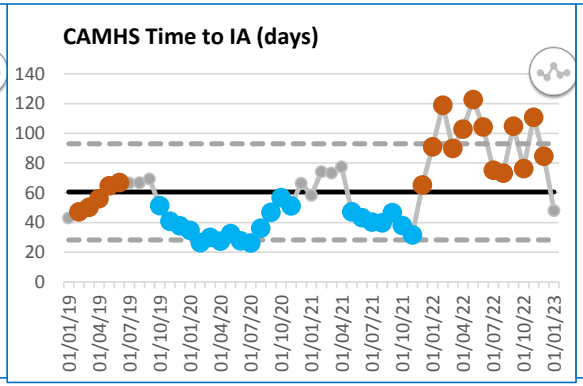


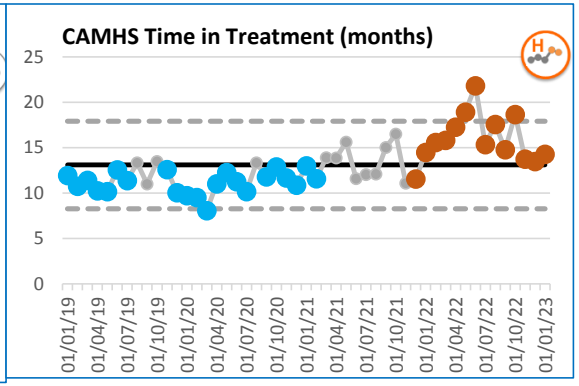
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Older Adult Community Mental Health Services	Step change increase in referrals for Dementia assessments has been seen, however appears to be stabilising. In Herts the EMDASS service was temporarily halted due to re-deployment of staff over the winter in 2021-2 which led to a backlog of diagnosis. Overall time spent on treatment pathways has reduced in all older adult services. Net impact on treatment caseload is that they remain flat overall with a slight increase in January.	Not meeting access standards for referral to diagnosis for Dementia (EMDASS) Recruitment vacancies for Consultants, Registered Nurses, OT's in West Essex – impact Occupational Therapists Demand and capacity modelling indicates that demand is going to outstrip capacity across the ICB. Access to specialist brain imaging/scanning in West Essex	Recovery programme activity for EMDASS diagnosis service in HPFT – expected to recover in Q1, 2023 New targeted workforce taskforce to look at recruitment in West Essex Future expansion of community diagnostic capacity across ICB; see slide 18. Assessing impact of new dementia drugs and impact on diagnostic and imaging services, to be updated in Qtr 4.	Risk review and prioritisation for service users who have been waiting Additional clinics for evening and weekends to improve waiting times Primary care dementia diagnosis nurses improving activity with a focus in West Essex on care home population. Sharing of best practice across the ICS.

Mental Health – CAMHS Services



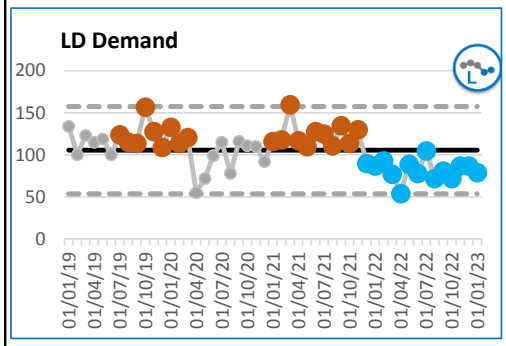


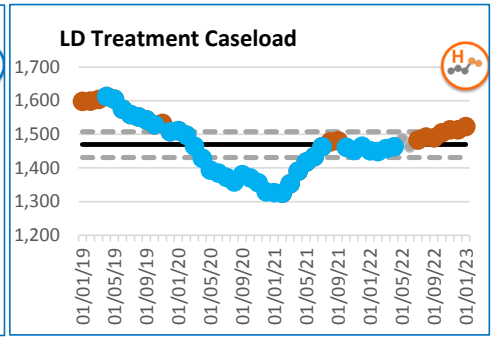


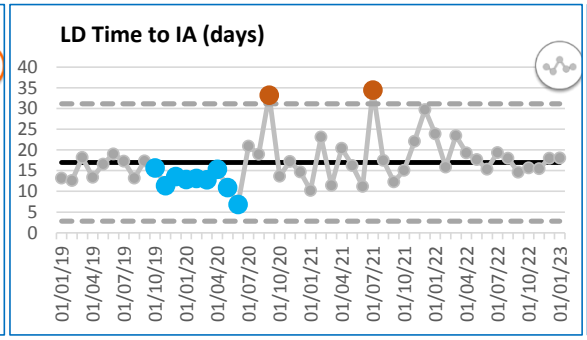


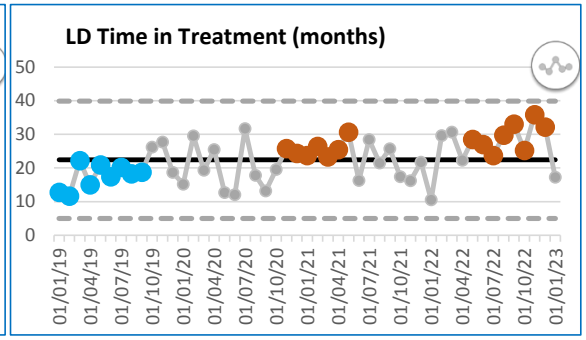
ICB Area	What the charts tell us	Issues	Actions	Mitigation
CAMHS	Referrals into CAMHS have passed 1,000 per month over the last 12 months (20% up from pre-pandemic levels). This has translated to pressure on initial assessments but has not yet converted into increased caseloads in CAMHS. From Jan 2022 we have not met the performance KPI for initial assessments (Choice) – in Hertfordshire Referral to treat times are reported as being met across the ICB – Herts and West Essex Length of time from referral to discharge has started to improve over the last few months with robust processes in place.	Referral demand has led to an increase in the number of initial assessments we need to provide. Some services have seen unexpected demand (e.g. Tier 3 Specialist CAMHS ED, Crisis, and Looked after children).	Recovery programmes in place for CAMHS i.e. 28 days, CAMHS ED, CAMHS Crisis, due to recover in Q4. Roll out in January for ADHD diagnostics and medicines initiation pathway. Recruitment underway for additional nurse and consultant support in South Hertfordshire. In West Essex we invested early in growing the Crisis and Eating Disorder Team resulting in being in the top 5% of ED performance nationally.	SPA Triage Tool improved to meet 5 day pass on to teams Job planning to continue in all quadrants to ensure personalised care Demand and capacity review underway to assess post-covid requirements. Recovery for referral to assessment times to 28 days expected in Q4 2022/23. Focus on prevention and community support in West Essex to help alleviate demand and improve service user experience through early intervention.

Mental Health – Learning Disabilities Services



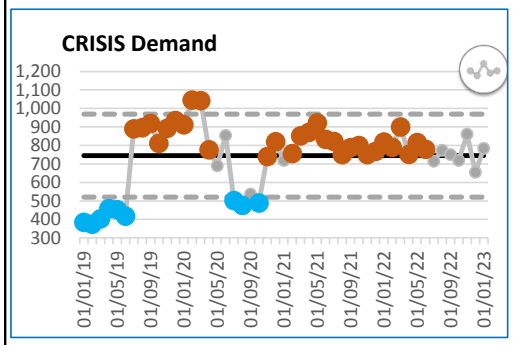


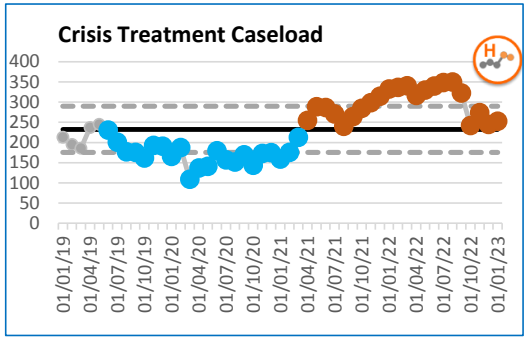


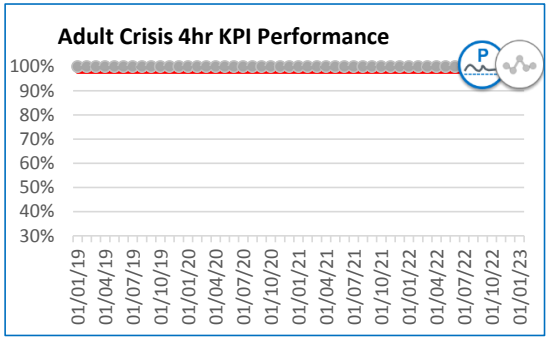


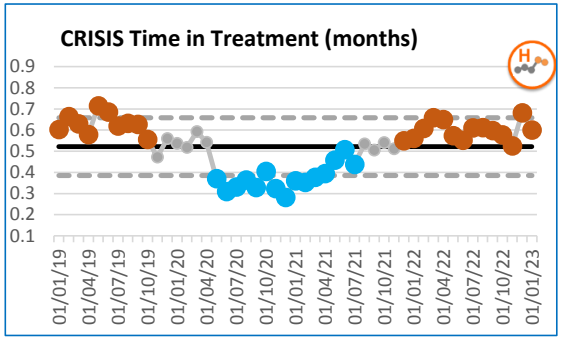
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Learning Disabilities Service Herts only	Referrals and caseloads services dropped during Wave 1 and Wave 2 of the pandemic but have returned to pre-pandemic levels. Service Users are seen consistently within 28 days of referral and the average time it takes from referral to a completed assessment is 17 days	None to report Successful re-integration of LD services in Essex enabling further opportunities for integrated learning and service delivery.	New service user and carer engagement and involvement programme aimed at improving care planning, service delivery and outcomes for LD service users across Herts and Essex.	Focus on reducing secondary waits and care co-ordination and risk management during wait periods. Working with commissioners ensure that GPs are aware and know how to refer directly into LD services.

Mental Health – Crisis Services



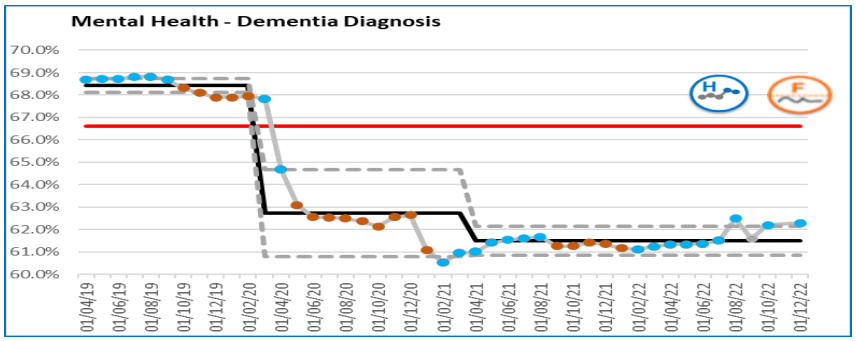


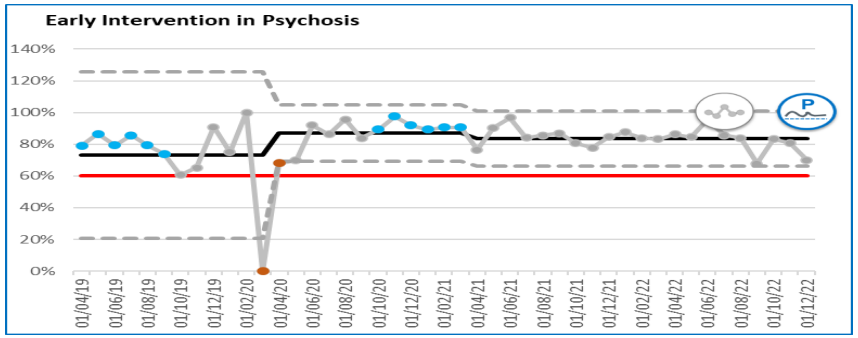




ICB Area	What the charts tell us	Issues	Actions	Mitigation
Crisis Services – Adults and Older Adults	Crisis demand has flattened over the last quarter bur referrals remain 46% higher than historic baseline levels. Caseload levels are reducing but remain high when compared to historic baselines. Service Users are seen consistently within 4 hours of referral and the average time under caseload management in the Crisis and Home Treatment Team is 1 month Note: In Essex, Crisis teams do not own team caseloads in favour of being an extension of the community team	High turnover on the Crisis and Home Treatment Team (CRHTT) led to pressure on the service.	Rolling recruitment and training for CRHTT. Reviewing different models of care including to improve safety, patient experience and outcomes.	Agency support for community teams releasing staff stepping up into CRHTT roles. Developed range of crises alternatives in third sector including Night Light, Night Owls, Trinity and Sanctuary.

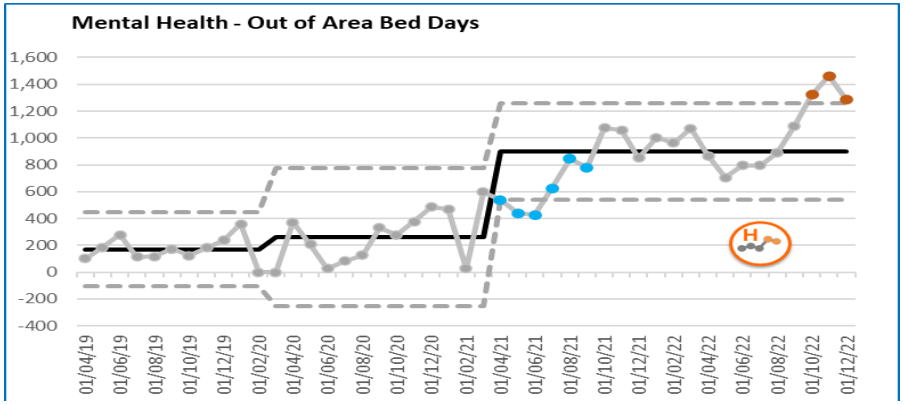
Mental Health – Dementia Diagnosis and Early Intervention in Psychosis (EIP)





ICB Area	What the charts tell us	Issues	Actions	Mitigation
ICB	• Recorded Dementia Diagnosis in January 2023 for Hertfordshire improved to 59.95% although remains below standard. The estimated population numbers for Hertfordshire changed in the national data collection for these publications. A total of 868 people are required to meet the target. West Essex continue to meet target at 68.3%. • The EIP national standard continues to be achieved in all three Places.	**Dementia Diagnosis Herts** • Waiting list remains high at 800 • Only 37% are seen within 12 weeks (80% target) • Commissioners chasing for Practice Data to review monthly in order to offer support to the poor performing practises.	**Dementia Diagnosis Herts:** • Recovery action plan agreed with actions commencing in January 2023 • Staffing: Now fully recruited to the total number of four Dementia Specialist Nurses, who are working at the Primary Care Networks, and focusing on the over 80s • Conversion rate is improving at 61% with the support of region • Framework (ECF) for GPs to complete coding exercise to capture true diagnosis rate • Admin role in Primary Care Diagnosis Service to free Nurse Specialists	**Herts:** • Continue with current actions to increase access to Dementia Diagnosis services • Dementia Diagnosis actions will deliver recovery to trajectory by 2023/24 • Bring Recovery Action Plans into one forum to ensure central oversight • Ongoing support to identify causes of low conversion rates at memory clinics

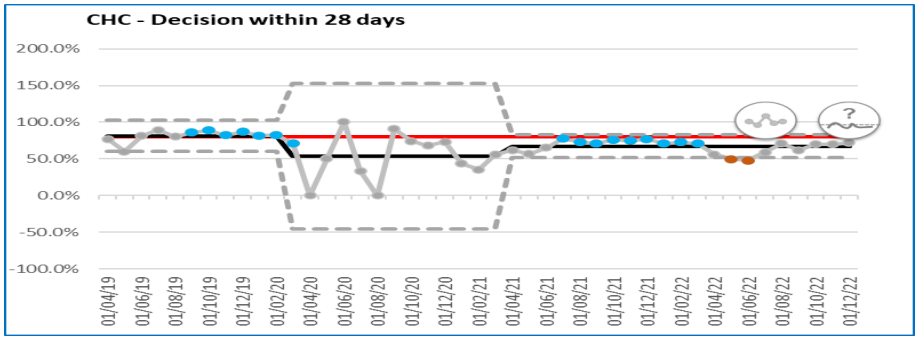
Mental Health – Out of Area Bed Days

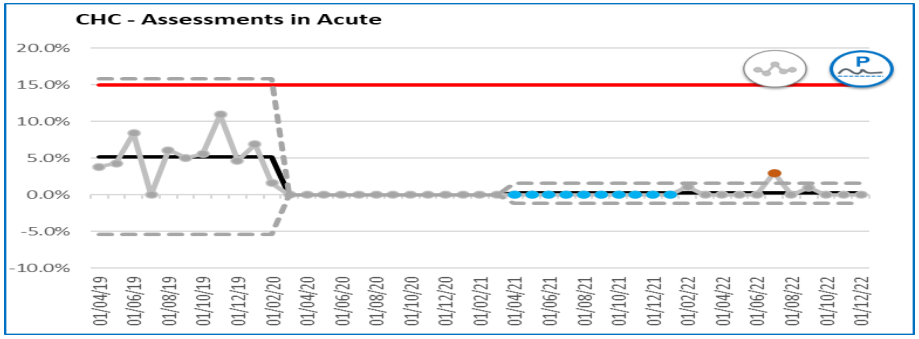


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Hertfordshire	100	185	277	114	118	172	124	182	239	360			372	207	26	83	125	331	277	376	486	471	26	596	452	337	336	574	834	759	936	745	674	779	830	987	767	691	775	757	817	1034	1177	1221	1080
Hertfordshire Target	66	132	200	58	116	175	50	100	150	42			33	33	34	20	20	20	10	10	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WECCG																									86	102	90	51	12	22	140	314	177	225	134	83	100	16	21	38	76	55	145	242	209

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• Out of Area Bed Days peaked in November, but from December started to reduce as forecast • Indicative January data is showing a further small improvement	• Pressure for Mental Health increased substantially over the Covid period, and has continued post-Covid, coupled with winter pressures, leading to a national shortage of beds, high occupancy rates and use of OOA beds	• SMART (Surge Management and Resilience Toolset) providing real time ward data • Essex review of bed model has identified county-wide issues with oversight and availability of bed stock and voids. Further work underway to address • Multi Agency Discharge Event (MADE) completed in January will inform bed model further work above	• Out of Area Placement (OOAP) Elimination & Sustainability Impact System Group (Essex wide) in place to monitor the impact of the NHSE OOAP Action Plan • Continued engagement with national Getting It Right First Time (GIRFT) programme to identify areas of improvement • Bed management system and new arrangements in place to monitor demand and capacity • In addition, new standard operating procedures in place to improve flow • Integrated Discharge Team approach is being scoped out in Herts to improve coordination of discharges for service users with complex needs requiring multiagency support
Herts	• Out of Area Bed Days remain high in December but did see a reduction from November	• Demand is continuing to exceed capacity • Low number of beds per population • Pressure for MH beds increased substantially over Covid, and post-Covid, a national shortage of beds, high occupancy rates and use of OOA beds is likely to continue • Challenges finding suitable placements for service users with complex needs • Workforce recruitment across inpatients & community, affecting capacity.	• Robust Gatekeeping process; on call gatekeeping consultant and clear reasons for admissions •Daily OOAP reviews /dedicated clinical ownership for OAP •Multi Agency Discharge Event (MADE) in January highlight issues, review DTCs and plan discharges with ongoing regular MADE events • Plan to increase block beds to improve flow across the system • 1st regular meetings with ICB, HPFT and Performance to review the inpatient data in Feb 2023.	

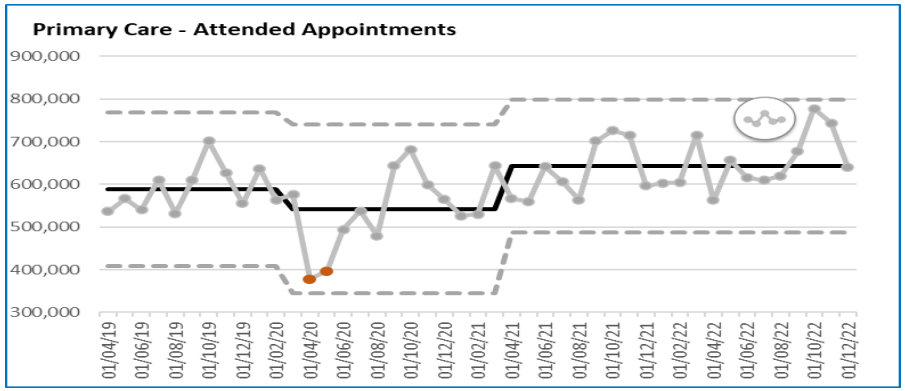
Continuing Health Care (CHC)

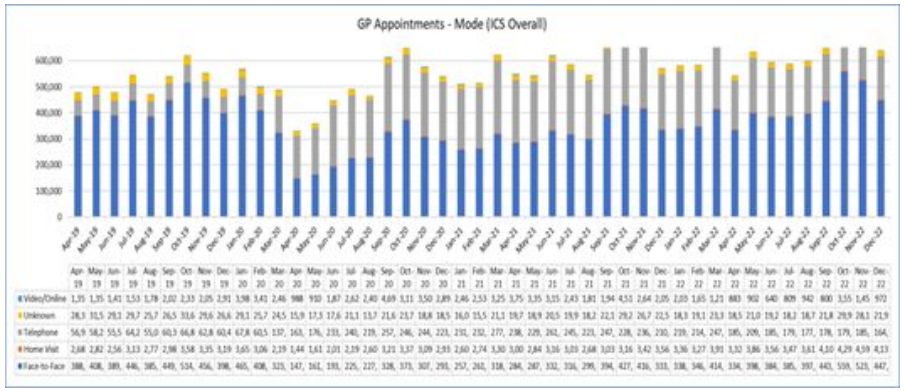




ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• 78% of CHC referrals in West Essex resulted in a decision within 28 days, falling below target. • No patients received assessments in an acute setting	• Further deterioration in performance forecast for Jan, but significant improvement expected in Feb. Team are optimistic that the 80% target will still be achieved across Q4 • Delayed allocation of Social Workers from Essex CC during Dec & Jan • An increasing trend in the number of D2A cases received. • Ongoing increasing backlog of CHC, FT and FNC reviews due to prioritising new assessments.	• The West Essex CHC Team continues to work alongside EPUT to provide additional resource and support. • Recruitment for vacancies ongoing. 1 nurse recruited in the last round of interviews. • New reviews project commenced to try and reduce increasing backlog.	• SWH action plan in place, supported by NHSEI • Performance standards continue to be monitored, issues escalated and risks mitigated • Agency cover requested for vacancies whilst recruitment continues • Setting trajectory and drive on clearing cases over 28 days
South West Herts / WHTHT	• Performance against decisions within 28 days remains below the expected 80%; most recently at 58%. • No patients received assessments in an acute setting.	• Workforce issues, progress with recruitment • Ongoing backlog of CHC & FNC reviews due to prioritising new DSTs and checklist completion. • Referrals numbers continue to be high. • Workforce issues including high number of resignations within the senior members of the team.	• Recruitment drive continues, interim cover in place to support the gaps. • Prioritisation of fast track and 1:1 reviews. • Allocation and weekly tracking of 28 day assessments remains a priority • Case management in place for all cases over 6 weeks. • Collaborative working with system partners; weekly meetings with LA. • Face to face Nursing needs assessments are completed and evidenced. • Focus on checklist completion, resulting in backlog reducing.	
East & North Herts / ENHT	• 88% of CHC referrals in East & North resulted in a decision within 28 days, meeting standard. • No patients received assessments in an acute setting	• Workforce issues such as sickness and annual leave • Ongoing delays receiving signed assessment paperwork from community, particularly Mental Health, may impact performance going forward	• Weekly tracking of referrals over 28 days by caseload and CHC manager • Performance levels expected to be achieved	

Primary Care





ICB Area	What the charts tell us	Issues	Actions	Mitigation
ICB	• Total appointments increased significantly in September, October and November • December saw reduced appointments, but this is likely explained by the bank holidays/Christmas period • The proportion of face to face appointments continues to increase and was over 70% in October, November and December.	• General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal • Significant pressure from Respiratory illness • Rapid increase in 'spot booking' hotels set up without notice by Home Office to house asylum seekers with significant health needs, including Scabies and Diphtheria outbreaks.	• Continue to implement actions funded by the Winter Access Fund, inc. advanced telephony and offsite storage of notes • An MDT group has been established to review the National GP Patient Survey (GPPS) data, and to develop an access framework and work programme • Working closely with BI team to develop an access dashboard for better monitoring of pressures • Primary Care Commissioning Committee (PCCC) has approved ICB funding for additional winter capacity in general practice. Funding is the same as last year at £1.43 per weighted patient • There is national repurposing of Investment & Impact Fund monies to support additional capacity • Acute Respiratory Infection hubs set up to assist with system pressures and minimise flow back to General Practice from 111 and ED • Enhanced Commissioning Framework re-prioritised to assist with practice capacity • Practices offered an extended period (additional 3 months) in which to achieve their QOF targets to recognise the ongoing prioritisation of on the day demand over winter.	• Continue to support return of business as usual to General Practice through the relaunch of the ECF across the ICB, supported by investment reporting to free up practice capacity • QOF period extension means that some annual review action for LTC will be reprofiled to spring and should have a benefit next winter • Continued access trend analysis in the 3 places to identify individual practices with poor access through complaints and patient contacts • PCCC and Primary Care Board oversight of the GPPS results, and action plan developed through the Access MDT Group • Recruitment & Retention of Primary Care Workforce – a number of initiatives are offered to the Primary Care Workforce to support recruitment and retention which are supported by the HSE ICB Training Hub • Continued funding for spot booking hotels for health checks and MDT site visits agreed by PCCC at the February meeting • Daily review of OPEL reporting by practices and follow up by place Primary Care Teams with individual practices continuing.

Appendix A – Performance Dashboard

December 2022

Herts & West Essex ICS (Commissioner)

Area	Activity	Target	Latest published data	Data published	Trend *1	Variation	Assurance	National position (ICB vs National)	Regional position (ICB vs EoE Region)	ICB Ranking
111	Calls answered < 60 seconds	95%	14.7%	December 22	-287.78%			20.52% (Worse)	15.75% (Worse)	11th lowest
	Calls abandoned after 30 seconds	5%	42.4%	December 22	82.75%			34.88% (Better)	32.26% (Worse)	17th (middle)
A&E	% Seen within 4 hours	95%	66.2%	January 23	8.91%		F	72.4% Worse)	54.35% (Better)	8th lowest
	12 Hour Breaches	0	225	January 23	-46.67%			42,735	3,654	7th highest
Cancer	2ww All Cancer	93%	85.0%	December 22	3.39%		F	80.29% (Better)	72.33% (Better)	18th highest
	2ww Breast Symptoms	93%	78.0%	December 22	1.53%			72.47% (Better)	53.70% (Better)	21st highest
	31 day First	96%	94.7%	December 22	0.94%			92.67% (Better)	92.55% (Better)	20th highest
	31 day Sub Surgery	94%	80.3%	December 22	-4.55%			81.86% (Worse)	75.32% (Better)	18th lowest
	31 day Sub Drug	98%	99.0%	December 22	0.23%			97.89% (Better)	97.40% (Better)	21st highest
	31 day Sub Radiotherapy	94%	94.9%	December 22	0.60%			90.71% (Worse)	92.63% (Better)	22nd lowest
	62 day First	85%	70.5%	December 22	7.20%		F	61.76% (Better)	62.80% (Better)	7th highest
	62 day Screening	90%	81.6%	December 22	22.05%			73.00% (Better)	76.19% (Better)	12th highest
	62 day Upgrade	85%	79.5%	December 22	10.79%			77.41% (Better)	78.06% (Better)	19th highest
RTT	Incomplete Pathways <18 weeks	92%	54.3%	December 22	-2.86%		F	58.02% (Worse)	54.81% (Worse)	11th lowest
	52 weeks	0	12,021	December 22	7.35%	H	F	382,090	55,828	8th lowest
Diagnostics	6 week wait	1%	36.7%	December 22	18.01%		F	31.28% (Worse)	35.96% (Worse)	16th lowest

Individual Trust

ICS Aggregate Provider	Trend	ENHT	Trend	PAH	Trend	WHTHT	Trend
14.7%	-287.78%	See individual CCG performance in the table below					
42.43%	82.75%						
66.20%	8.91%	64.60%	4.88%	54.40%	6.50%	68.40%	12.35%
225	-46.67%	123	-55.28%	80	-73.75%	22	100.00%
85.36%	1.84%	94.49%	-2.75%	72.60%	-8.05%	87.20%	11.75%
78.11%	-0.51%	92.42%	-8.20%	84.38%	-10.34%	66.67%	42.86%
95.58%	0.78%	97.13%	1.03%	91.36%	2.98%	95.68%	-0.09%
93.94%	-0.85%	94.59%	-2.07%	77.78%	-7.14%	100%	4.55%
99.55%	-0.08%	100%	0.00%	93.75%	-6.67%	100%	3.57%
97.31%	5.44%	97.31%	5.44%	N/A		N/A	
73.98%	4.77%	90.95%	11.30%	47.37%	-17.49%	69.53%	7.44%
74.14%	23.30%	70%	-4.76%	83.33%	68.00%	70%	4.76%
75.63%	12.17%	71.05%	3.24%	85.45%	11.58%	61.54%	10.11%
50.33%	-2.95%	50.52%	-6.68%	48.41%	-4.33%	51.16%	2.00%
10,095	-5.11%	4,778	3.35%	1,773	2.93%	3,544	-20.54%
42.30%	16.25%	50.65%	14.98%	35.47%	27.14%	35.04%	14.00%

Herts & West Essex ICS (Commissioner)

Area	Metric	Target	Latest published data	Data published	Trend *	Variation	Assurance	National position (ICB vs National)	Regional position (ICB vs EoE Region)	ICB Ranking
111	Calls answered < 60 seconds	95%	14.7%	December 22	-287.78%			20.52% (Worse)	15.75% (Worse)	11th lowest
	Calls abandoned after 30 seconds	5%	42.4%	December 22	82.75%			34.88% (Better)	32.26% (Worse)	17th (middle)
Mental Health	Dementia Diagnosis rate	66.6%	62.3%	December 22	0.13%		F	62.50% (Worse)	60.20% (Better)	n/a
	OOA placements	0	1,289	December 22	-13.50%		F	n/a	n/a	n/a
CHC	% of eligibility decisions made within 28 days	80%	72.1%	December 22	3.12%		F	n/a	n/a	n/a
	% of assessments carried out in acute	15%	0.0%	December 22	0.00%		P	n/a	n/a	n/a

Individual CCGs

ICS Aggregate Provider	Trend	East & North Herts	Trend	South & West Herts	Trend	West Essex	Trend
N/A		14.46%	-297.05%			15.65%	-253.86%
		41.76%	82.31%			44.90%	80.40%
		59.70%	-0.14%	61.67%	0.64%	68.34%	-0.28%
		1,080	-13.06%			209	-15.79%
		88.46%	21.21%	57.58%	-9.50%	77.78%	-4.76%
		0%	0.00%	0%	0.00%	0%	0.00%

LEGEND On/above target | Below target | Improvement on previous month's performance | Decrease on previous month's performance | No change on previous month's performance

*1 Against last month's performance

Variation: Special Cause Concerning variation; Special Cause Improving variation; Common Cause

Assurance: Consistently hit target; Hit and miss target subject to random variation; Consistently fail target

Appendix B: Urgent & Emergency Care (UEC) by Place

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• Attendances peaked in December, but January saw a reduction to the lowest level this year • Number of patients experiencing handover delays >30 minutes in December was largely unchanged. The recovery trajectory is not being achieved • 13.1% of patients spent >12 hours in ED, continuing a 12 month above average trend • The number of patients treated, admitted or discharged in under 4 hours just 50.9% in December, but did improve by 3.5% in January	• Continued high attendances • Ambulance Handover Delays • ED staffing, vacancies & sickness • Covid patients within the Trust and contact beds closed impacting capacity and flow • MH assessments and bed shortages (national issue) • Estate footprint & size of dept	• Daily joint working with all system partners to create ED capacity aligned to local oversight arrangements • Daily calls and CCG support with discharges and Transport • Daily calls with EEAST to review pressures across local Trusts and enact "load levelling" • Nightingale Ward (18 beds) available as per escalation plans and staffing availability • Continue with established safety huddles and harm review arrangements • March 23 improvement ambitions for the 6 national UEC priority metrics have now been agreed across the ICS and will be overseen in West Essex at the Local Delivery Board (LDB) • IN / OUT patient flow programmes established • Recent appointments of an ED Nurse Consultant and a UEC Head of Nursing • Relocation of the discharge lounge to create additional ED capacity - delayed until February	Actions in place to ensure that patient safety is maintained SRG/LDB work plans agreed in line with NHSE planning guidance and Board Assurance Framework. Performance Improvement Trajectories aligned to action plans; Feb UEC Board and SRG/LDB focus on further actions required to return performance to improvement trajectories
South West Herts / WHTHT	• High number of attendances continued throughout December (16,600), with a sharp decrease in January 2023 to 14,100 • 4 hour ED performance improved throughout December and January (mirroring attendances). December saw performance of 60% with an improvement to 68% in January 2023 • 5.4% of patients spent >12 hours in ED during November; this was an improvement on the previous months figure of 6.5% • 55.7% of patients with NCTR remaining in hospital is an increase on the previous month (54.1%)	• The high number of MH presentations continued during December but the numbers have sharply declined in January (both in ED and on the wards). • Continued high numbers of NMCTR in both WHTHT and CLCH beds • MH assessments and bed shortages (national issue) • 120+ surge beds open during Dec	• St Albans Integrated Urgent Care Hub (IUCH) in fourth month of operation. Substantive staff recruited and in place . Radiology issues Mon-Fri have been resolved with full minor illness and minor injury profile available. Weekend radiology under development between ICB and WHTHT. • Care connect a challenge in facilitating GP referrals to the IUCH. Workaround remains in place • Utilisation of the IUCH steadily increased and amendments been made to the DOS ranking to facilitate increased 111 referrals to the IUCH; raised utilisation to >60%. • Tranche 3 schemes continue to be implemented where they can • EEAST working with WHTHT to convey appropriate patients direct to Watford UTC • 35 nurses recruited across Emergency Medicine and 4 additional consultant posts approved • Virtual Ward capacity expanding	
East & North Herts / ENHT	• Handover performance improved over the two months to December, returning to meet improvement trajectory for <30 mins; • ED attendances remain at higher levels however a reduction was seen in January to lowest in 22/23; • ED 4 hour performance continued to see a second month of improvement in Jan at just under 65%; • The % of patients spending more than 12 hours in the dept remains high increasing to 10.5% in the latest data; • % of patients not meeting criteria to reside & not discharged remains high.	• Increased levels of ED attendances through to December with acuity remaining high • Ambulance handover delays • ED staffing - vacancies and sickness/isolation • Covid and Flu patients within the Trust, contact beds closed impacting capacity and flow • MH assessments and bed shortages	• 2 key elements of the UEC Transformation action plan have been successfully introduced, including the opening of the new Assessment/SDEC area and the 'pull for safety ' model across the speciality assessment areas; • Wider pull for safety actions continue to take pace with an incremental roll out over the coming weeks; • Zero tolerance to excess handover delays continue and reduced to 1 hour in Jan; • Paediatrics were given 60 GP slots per day for redirection to support increased activity associated to STREP A; • The temporary Ambulance Handover Unit opened in late December, providing 5 additional ED trolley spaces. • Tracking against March 23 improvement trajectories for UEC priority metrics overseen in ENH through the SRG.	

Appendix C: Performance v. 22/23 Operational Plans by Place

East and North Herts Trust

Baseline	22/23 Activity Plan	22/23 M1-9 Activity Plan
104,880	138,641	101,728
	+32%	
N/A	0	0
N/A	0	237
3313	2914	3151
400,242	359,706	278,384
	-10%	
N/A	4.7%	3.1%
0%	26%	26%
N/A		
180,261	184,372	142,809
	+2%	
87	87	155
75%	74%	75%

Area	Target
Activity	10% elective activity increase (19/20 levels RTT pathway)
Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)
	Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)
	52 week waits trending down across 22/23
Outpatients	25% reduction in outpatient follow-ups by 2023
	5% of outpatients moved or discharged to PIFU
	25% of consultations via video/telephone
	16 specialist advice requests per 100 outpatient firsts
Diagnostics	20% increase in diagnostic capacity against 19/20 levels
Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels
	Reduction in missed 28 day cancer decisions

	M1-9 Actual									
	April	May	June	July	August	September	October	November	December	Total
Plan	7,816	8,554	11,535	12,112	12,688	12,688	12,112	12,688	11,535	**101,728**
Actual	7,816	9,494	9,139	8,072	8,241	9,353	9,015	10,187	7,364	**78,681**
Variance	0	940	-2,396	-4,040	-4,447	-3,335	-3,097	-2,501	-4,171	**-23,047**
Actual	96	56	21	9	7	2	2	3	3	**3**
Actual	439	408	324	312	407	458	464	548	689	**689**
Actual	3473	3699	4027	4294	4628	4688	4527	4618	4778	**4778**
Plan	33,377	33,990	31,737	34,856	28,372	28,950	31,901	30,135	25,066	**278,384**
Actual	30,904	34,899	31,661	31,545	32,011	33,021	32,679	35,982	32,050	**294,752**
Variance	-2,473	909	-76	-3,311	3,639	4,071	778	5,847	6,984	**16,368**
Actual	0.6%	0.7%	0.7%	0.6%	0.8%	0.8%	0.9%	1.0%	1.2%	**1.2%**
Actual	26%	26%	26%	27%	25%	26%	26%	27%	26%	**26%**
Actual	24	24	23	24	24	22	22	21	20	**23**
Plan	14,839	16,359	16,071	16,432	15,611	15,674	16,429	15,456	15,009	**141,880**
Actual	11,414	13,529	13,068	12,957	13,040	13,439	13,731	14,492	12,734	**118,404**
Variance	-3,425	-2,830	-3,003	-3,475	-2,571	-2,235	-2,698	-964	-2,275	**-23,476**
Actual	322	275	306	304	329	221	242	203	256	**256**
Actual	68%	64%	71%	72%	73%	70%	72%	72%	77%	**70%**

Target Achievement @ M9
+0%
Trending down
Up at Month 9
Increasing
-2%
1.2%
26%
23
-13%
Remains high
% within 28 days increasing

Appendix C: Performance v. 22/23 Operational Plans by Place

PAH

Baseline	22/23 Activity Plan	22/23 M1-9 Activity Plan	Area	Target
70,011	75,816	56,028	Activity	10% elective activity increase (19/20 levels RTT pathway)
	+8%			
N/A	0	0	Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)
N/A	0	160		Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)
1737	3,059	3,206		52 week waits trending down across 22/23
225,486	271,151	202,475	Outpatients	25% reduction in outpatient follow-ups by 2023
	+20%			
N/A	2.0%	1.7%		5% of outpatients moved or discharged to PIFU
4%	27%	27%		25% of consultations via video/telephone
N/A				16 specialist advice requests per 100 outpatient firsts
110,523	117,630	88,074	Diagnostics	20% increase in diagnostic capacity against 19/20 levels
	+6%			
121	75	75	Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels
61%	73%	75%		Reduction in missed 28 day cancer decisions

	M1-9 Actual										Target Achievement @ M9
	April	May	June	July	August	September	October	November	December	Total	
Plan	5,317	5,941	6,678	6,643	5,902	6,232	6,484	6,824	6,007	**56,028**	-1%
Actual	5,317	6,088	5,911	5,646	5,644	5,953	6,076	6,220	4,669	**51,524**	
Variance	0	147	-767	-997	-258	-279	-408	-604	-1,338	**-4,504**	
Actual	14	12	10	3	0	0	0	0	0	**0**	At Zero
Actual	223	266	281	296	248	208	141	108	157	**157**	Up at Month 9
Actual	1818	1674	1785	1911	1909	1898	1804	1721	1773	**1773**	Remains high
Plan	19,736	22,231	23,018	23,120	22,398	22,968	23,099	23,179	22,726	**202,475**	+3%
Actual	19,754	22,354	19,593	18,917	18,371	17,497	18,088	19,628	20,769	**174,971**	
Variance	18	123	-3,425	-4,203	-4,027	-5,471	-5,011	-3,551	-1,957	**-27,504**	
Actual	0.9%	1.4%	1.5%	1.3%	1.4%	1.4%	1.4%	1.6%	1.2%	**1.2%**	1.2%
Actual	27%	27%	28%	28%	27%	28%	28%	31%	31%	**28%**	28%
Actual	5	5	5	5	6	5	5	5	4	**5**	5
Plan	9,258	9,852	9,852	9,852	9,852	9,852	9,852	9,852	9,852	**88,074**	+3%
Actual	9,258	9,793	9,073	9,604	10,193	9,242	9,491	9,888	8,087	**84,629**	
Variance	0	-59	-779	-248	341	-610	-361	36	-1,765	**-3,445**	
Actual	182	156	128	125	162	152	163	149	193	**193**	Remains high
Actual	64%	66%	74%	72%	73%	68%	70%	74%	75%	**70%**	% within 28 days increasing

Appendix C: Performance v. 22/23 Operational Plans by Place

West Herts Teaching Hospitals Trust

Baseline	22/23 Activity Plan	22/23 M1-9 Activity Plan	Area	Target
71,713	115,674	80,676	Activity	10% elective activity increase (19/20 levels RTT pathway)
	+61%			
N/A	0	2	Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)
N/A	0	29		Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)
1059	507	588		52 week waits trending down across 22/23
330,892	260,127	197,020	Outpatients	25% reduction in outpatient follow-ups by 2023
	-21%			
N/A	2.1%	1.7%		5% of outpatients moved or discharged to PIFU
8%	25%	24%		25% of consultations via video/telephone
N/A				16 specialist advice requests per 100 outpatient firsts
126,398	146,816	107,009	Diagnostics	20% increase in diagnostic capacity against 19/20 levels
	+16%			
81	105	136	Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels
72%	69%	79%		Reduction in missed 28 day cancer decisions

	M1-9 Actual										Target Achievement @ M9
	April	May	June	July	August	September	October	November	December	Total	
Plan	3,682	5,002	4,373	11,865	10,553	11,397	11,871	11,579	10,354	**80,676**	-22%
Actual	3,682	4,999	4,816	4,618	4,948	5,633	6,116	6,860	5,376	**47,048**	
Variance	0	-3	443	-7,247	-5,605	-5,764	-5,755	-4,719	-4,978	**-33,628**	
Actual	14	9	4	3	2	3	2	2	0	**0**	At Zero
Actual	144	155	143	133	137	116	92	69	69	**69**	Decreasing
Actual	1193	1431	1660	1783	2078	2587	3413	4272	3544	**3544**	Increasing
Plan	18,976	20,461	18,963	24,263	24,082	23,655	22,741	22,803	21,076	**197,020**	-21%
Actual	19,598	22,104	21,299	21,019	21,732	22,226	22,042	24,789	19,903	**194,712**	
Variance	622	1,643	2,336	-3,244	-2,350	-1,429	-699	1,986	-1,173	**-2,308**	
Actual	0.7%	0.9%	1.0%	0.8%	0.8%	0.6%	0.4%	0.1%	0.1%	**0.1%**	0.1%
Actual	15%	13%	14%	13%	13%	14%	14%	14%	13%	**14%**	14%
Actual	47	46	46	50	48	45	45	44	41	**46**	46
Plan	9,652	10,497	9,095	13,595	12,379	12,660	13,373	13,068	12,690	**107,009**	-38%
Actual	9,357	10,546	9,827	9,473	9,835	9,922	9,321	10,736	8,895	**58,960**	
Variance	-295	49	732	-4,122	-2,544	-2,738	-4,052	-2,332	-3,795	**-48,049**	
Actual	261	297	297	277	270	257	233	195	191	**191**	Decreasing
Actual	51%	58%	56%	60%	60%	58%	63%	72%	73%	**60%**	% within 28 increasing

Appendix D: HWE Adult Community Services

Elective & Specialist	E&NH	S&WH	West Essex
Cardiac Rehab	HCT/ENHT	CLCH	EPUT
Diabetes	HCT	HCT	EPUT
Continence services	HCT	CLCH	EPUT
Nutrition and Dietetic Service	HCT	HCT	EPUT
Speech and language therapy	HCT	CLCH	EPUT
Podiatry	HCT	CLCH	EPUT
Specialist palliative care	HCT	CLCH	EPUT
Heart failure service	-	CLCH	EPUT
Lymphoedema	HCT	CLCH	HCT
Tissue Viability	HCT	CLCH	EPUT
Leg Ulcer	HCT	CLCH (Herts one)	EPUT
Respiratory	HCT/ENHT	CLCH/WHHT	EPUT
MSK	HCT	Connect	EPUT
Chronic pain management	HCT	Connect	EPUT
Community Neuro/rehab	HCT	CLCH	PD/MS only
Pulmonary Rehab	HCT	CLCH	EPUT
Specialist Dentistry	HCT	HCT	-
Community Dermatology	HCT	-	GP Fed
Community ENT	-	Communitas	-
Community Gynaecology	-	The Gynaecology partnership	-
Long Covid	HCT	CLCH	EPUT
Diabetes eye screening	ENHT	HCT	Health intelligence Ltd
Sexual Health Services	CLCH	CLCH	Provide

Urgent & Emergency Services	E&NH	S&WH	West Essex
2 hour urgent response	HCT	CLCH	EPUT
Hospital at home/rapid response	HCT	CLCH	EPUT
Discharge to assess (at home)	HCT	CLCH	EPUT
Virtual ward/hospital	HCT	CLCH/WHHT	EPUT
Inpatient rehab beds	HCT	CLCH	EPUT
Inpatient stroke Neuro rehab beds	HCT	CLCH	EPUT
Respiratory services	HCT	CLCH	EPUT
Stroke (Early supported discharge)	HCT	CLCH	EPUT
Neuro ESD (NETT)	-	CLCH	-

Core community Services	E&NH	S&WH	West Essex
District Nursing	HCT	CLCH	EPUT
Community therapies (OT/PT)	HCT	CLCH	EPUT
Frailty clinics	HCT	CLCH	PAH
Enhanced health in care homes	HCT	CLCH	EPUT

Appendix D: HWE Children's Community Services

Children's Services within Hertfordshire and West Essex ICS is complex with a range of existing governance forums and a broad range of services provided primarily by NHS Trusts, but with a number of independent and 3rd sector organisations

Service	E&NH	S&WH	West Essex
ADHD	ENHT	HPFT	HCRG
Advocacy	KIDS	KIDS	Rethink / Open Door
Allergy	ENHT	WHHT	HCRG / PAH
ASD	ENHT	HCT	HCRG
Asthma Nurse specialist	n/a	HCT	To be established
Audiology	ENHT	HCT	PAH
Wellbeing Practitioners	HCT	HCT	HCRG
CHIS	HCT	HCT	Provide
Com. Nursing	ENHT	HCT	HCRG
Comm Paeds	ENHT	HCT	HCRG
Continence	n/a	HCT	HCRG
Continuing Care	ENHT	HCT	HCRG & Various Independent
CSAIS	EPUT (s/c HCT)	EPUT (s/c HCT)	EPUT
CYP Counselling	YCT, Youthtalk, Signpost, Rephael House & Safespace.	YCT, Youthtalk, Signpost, Rephael House & Safespace.	YCT
CYP Therapies	HCT	HCT	HCRG (SLT inclusive of dysphagia, PT inclusive of MSK)
Designated Medical Officer for SEND	ENHT	HCT	HCRG
Diabetes Nurse Specialist	ENHT	WHHT	PAH
Dietetics	HCT	HCT	HCRG / PAH
Eating Disorders	HPFT	HPFT	NELFT / BEAT
Epilepsy Nurse Specialist	ENHT	WHHT	PAH
Equipment	HCT	HCT	EPUT
Eye Care	ENHT	HCT/WHHT	PAH

Service	E&NH	S&WH	West Essex
Family Hubs/Children's Centres	Family Centre Services/Family Support Services/ HCT	Family Centre Services/Family Support Services/ HCT	HCRG
Health Visiting	HCT	HCT	HCRG
Hospice Care	Keech	Keech/Noah's Arc/ Rennie Grove	Haven House, EACH
Infant Mental Health	HCT	HCT	EPUT
LAC	HCT	HCT	HCRG
Lymphoedema	HCT	n/a	HCT
Mental Health Support Teams	HPFT/HCT	HPFT/HCT	West Essex Mind (mainstream) / HPFT (special schools)
Neuro-Rehab	Specialist commissioned	Specialist commissioned	Tadworth Children's Trust
Palliative Care Respite Service (EPIC)	Noah's Arc	Noah's Arc	Little Haven's
Palms	HCT	HCT	n/a
Parenting Support	HCC	HCC	Triple P (YCT from April)
Perinatal Mental Health	HPFT	HPFT	EPUT
School Nursing	HCT	HCT	HCRG
Sickle cell	HCT	HCT	PAH
Special care dentistry	HCT	HCT	PAH
Specialist CAMHS	ENHT	HPFT	NELFT
Specialist Healthcare Tasks	n/a	n/a	Provide
Specialist school nursing	ENHT	HCT	HCRG
Step 2 Service	JHCT	HCT	n/a
Therapeutic Health Based Coaching	n/a	n/a	NOW
Tier 4 CAMHS	HPFT	HPFT	EPUT
Transition coordinators	HCT	HCT	HCRG
Weight Management & other wellbeing services	Beezee Bodies	Henri/ Beezee Bodies	Provide

N.B. Virgin Care has now been transferred to HCRG Care Group

Glossary of Acronyms

>104 days	Cancer backlog greater than 104 days
>104 weeks	Elective Care backlog greater than 104 weeks
>62 days	Cancer backlog greater than 62 days
A&E	Accident & Emergency
AAU	Ambulatory Assessment Unit
AHC	Annual Health Check
BAME	Black Asian & Minority Ethnic
BAU	Business As Usual
CAMHS	Children & Adolescent Mental Health Service
CCATT	Children Crisis Assessment & Treatment Team
CCG	Clinical Commissioning Group
CDC	Cancer Diagnostic Centre
CEO	Chief Executive Officer
CHC	Continuing Healthcare
CISS	Community Intensive Support Service
CLCH	Central London Community Healthcare NHS Trust
CMO	Chief Medical Officer
CO	Carbon Monoxide
CQC	Care Quality Commission
CT	Computerised Tomography (scan)
CYP	Children Young People
D2A	Discharge to Assess
DMAS	Digital Mutual Aid System
DQ	Data Quality
DST	Decision Support Tool
DSX	DSX Systems (Digital Health Solutions)
DWP	Department for Work & Pensions
EAU	Emergency Assessment Unit
ECHO	Echocardiogram

ED	Emergency Department
EEAST	East of England Ambulance Service NHS Trust
EIP	Early Intervention in Psychosis
EMDASS	Early Memory Diagnosis and Support Service
EMIS	Supplier of GP Practice systems and software
ENHCCG	East & North Herts Clinical Commissioning Group
ENHT	East & North Herts NHS Trust
EPR	Electronic Patient Record
EPUT	Essex Partnership University NHS Foundation Trust
F2F	Face-to-Face
FDS	Cancer 28 day Faster Diagnosis Standard
FHAU	Forest House Adolescent Unit
FNC	Funded Nursing Care
GP	General Practice
HALO	Hospital Ambulance Liaison Officer
HCA	HealthCare Assistant
HCT	Hertfordshire Community Trust
HEG	Hospital Efficiency Group
HPFT	Hertfordshire Partnership NHS Foundation Trust
HUC	Hertfordshire Urgent Care
HVCCG	Herts Valley Clinical Commissioning Group
IAG	Inspection Action Group
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IPC	Infection prevention and control
IS	Independent Sector
IUC	Integrated Urgent Care

JSPQ	Joint Service, Performance and Quality Review Meeting
LA	Local Authority
LAC	Look After Children (team)
LD	Learning Disability
LeDeR	Learning Disability Mortality Review Programme
LFT	Lateral Flow Test
LMNS	Local Maternity Neonatal System
LMS	Local Maternity System
LoS	Length of Stay
MDT	Multi Disciplinary Teams
MH	Mental Health
MHSOP	Mental Health Service for older People
MOU	Memorandum Of Understanding
MRI	Magnetic Resonance Imaging
MSE	Mid & South Essex NHS Foundation Trust
NHSE / I	NHS England & Improvement
NICE	The National Institute for Health & Care Excellence
NLMCTR	No Longer Meets Criteria To Reside
NO	Nitrous Oxide
NOK	Next Of Kin
OHCP	One HealthCare Partnership
OOAP	Out of Area Placements
OT	Occupational Therapy
PAH / PAHT	The Princess Alexandra Hospital NHS Trust
PCN	Primary Care Network
PCR	Polymerase Chain Reaction (test)

PEoLC	Palliative & End of Life Care
PIFU	Patient Initiated Follow-Up
PMO	Project Management Office
PRISM	Primary Integrated Service for Mental Health
PTL	Patient Tracking List
RCA	Root Cause Analysis
REAP	Resource Escalation Action Plan
RESUS	Resuscitation
RTT	Referral to Treatment (18-week elective target)
SACH	St Albans City Hospital
SAFER	Tool to reduce patient flow delays on inpatient wards
SDEC	Same Day Emergency Care
SLT	Speech & Language Therapist
SMART	Surge Management and Resilience Toolset
SRG/LDB	System Resilience Group / Local Delivery Board
SSNAP	Sentinel Stroke National Audit Programme
T&O	Trauma and Orthopaedic
TTA	Take Home Medication (To Take Away)
UEC	Urgent Emergency Care
US	Ultrasound Scan
UTC	Urgent Treatment Centre
WAF	Winter Access Fund
WECCG	West Essex Clinical Commissioning Group
WGH	Watford General Hospital
WHHT	West Herts Hospital Trust
WW	Week Waits

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	16
Report title	Finance Performance and Planning Committee 28 March 2023 highlight report			**Meeting Date**	3 May 2023
Chair	Karen McConnell – Committee Chair and Non-Executive Director				
Author	Debbie Collins – Corporate Governance Officer				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Annual Cycle of Business
- Board Assurance Framework
- FPPC Committee Effectiveness
- Finance Report Month 11
- Financial Reset and outturn update
- Financial and Business Plan 23/24
- Urgent Emergency Care (UEC) Pathway Reconfiguration
- Procurement Delivery Update
- Performance Report Month 11
- New Performance Management Framework
- Infrastructure Development Procurement
- Maintenance Contract waiver

Alert:

- The Trust forecast a baseline deficit of £6.9 at year end. The upside and downside ranges were explained. The key drivers of the forecast deficit are medical staffing overspends and UEC Pressures, significant CIP slippage, higher than planned cost inflation, high-cost drug growth being below the 22/23 ICB block agreement, the mitigating impact on non-recurring reserves benefit, impact of NHS income overperformance and above plan pharmacy and pathology costs.
- The Committee was updated on the business planning process including the basis of negotiation over the distribution of funding allocations with the ICS and other system stakeholders and progress in the development of the elective recovery programme and UEC capacity enhancements required to deliver national priorities. From this paper the Committee noted key performance and delivery risks and in particular:
    - Non-compliance with the requirement to have no one waiting over 65 weeks at the end of March 2024, with 1535 expected breaches in community paediatrics.
    - Non-compliance with the requirement to reduce follow-ups by 25% compared to 2019/20 and currently predicting 4.4% of follow up patients on a PIFU pathway by March 24
    - The planned deficit of £13.8m which is in breach of the Trusts statutory responsibilities.
- The Committee were concerned about the ongoing high costs of staffing and low productivity and the lack of assurance over the CIP.

Advise:

- The FPPC Committee Effectiveness survey had been completed by 10 out of a possible 17 people. It concluded that overall the Committee was being run well and performing the duties set out in the Terms of Reference.
- A reduced theatre timetable had been implemented in response to the WLI dispute, resulting in less activity from November.
- Performance had been affected by the industrial action which took place in March and was expected to be affected further by the planned industrial action in April.
- The pay award through Agenda for Change had not yet been confirmed.
- There had been an increase in community paediatrics referrals from 170 to 270-300 per month. There was a national expectation of a reduction of 25% in follow up appointments. The Trust had not achieved this; however this was in line with other organisations in England.
- The Committee were advised that NHSE had an expectation that Trust's would not grow their establishment further in the coming year.
- The Committee were advised of steps being taken within the Trust to review each service's workforce numbers against their 19/20 baseline.
- The Committee raised a concern over the basis of the allocation of the system top-up across the ICS acute providers for 2023/24.

Assurance:

- External support from the national urgent emergency care team and ECST to assist with making improvements within the urgent emergency care pathway.
- The Committee were pleased to learn that procurement had spent less than budget and there had been savings made within the Trust and the ICS. The Committee also noted the challenges in the global supply chain.
- The Committee were assured that ambulance handover times had improved in January and February. It was expected that further improvements would be made with efficient use of the same day emergency care unit. Risks to sustaining improvements were noted.
- There had been a reduction in the number of cancer patients waiting more than 62 days.
- The Committee received an overview of the Performance Management Framework which would assist with delivery and performance management targets. The guiding purposes and principles were explained together with the key role that data analytics and balance scorecards will play. The new PMF will go live in the Month 1 reporting period for 23/24.
- The Committee approved waiver requests for the 3 year maintenance contracts of linacs at Mount Vernon Cancer Centre which were due to commence on 1/4/23.

Important items to come back to committee (items committee keeping an eye on):

- A workforce plan will be presented to the Committee in May.
- The Committee were provided with an explanation of the infrastructure development procurement and will receive a further update in July.
- Divisions will present there 23/24 CIP plans to FPPC in April

Items referred to the Board or a committee for a decision/action:

- None.

Recommendation	The Trust Board are asked to note the Finance Performance and Planning Committee report.

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	16
Report title	Finance Performance and Planning Committee 25 April 2023 highlight report			**Meeting Date**	3 May 2023
Chair	Karen McConnell - Committee Chair and Non-Executive Director				
Author	Debbie Collins – Corporate Governance Officer				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Divisional CIP Plan
- Medical Extra Contractual Rates Recruitment Plan
- Finance Report Month 12
- Financial Business Plan 23/24
- Performance Report Month 12
- ENH/HCP Priorities
- Surgical Pathway Spotlight
- Board Assurance Framework
- Terms of Reference

Alert:

- The Trust reported a £6.1m deficit at the end of the financial year, against a break-even plan. This will be subject to audit verification. The £6.1m reported deficit was £0.8m favourable to the £6.9m forecast deficit which was submitted and agreed by the ICB and NHSE.
- The Committee was updated on the 23/24 business planning process. The current progress by the Trust and HWE ICS in setting out a breakeven plan for 23/24 and the expected timeline was explained. The current gap in achieving the target was explored and discussed. Final operating plans will be submitted nationally on 4 May 2023. The Trust will be submitting plans to ICB colleagues on 28 April 2023.
- At the 25 April, the Trust has a deficit plan of £7.4. The risks around CIPs, bed funding, financial impact of industrial action and the revenue impact of digital were discussed, together with opportunities from further stretching CIPs, establishment reviews, ERF and delaying UEC investment. Further discussions will take place at Board.
- The four-hour ambulance handover against target had not improved in the last month. However, improvements from previous months had been broadly maintained despite a higher number of arrivals.
- Bed days for patients not meeting the criteria to reside was significantly higher compared to previous months. This continues to negatively impact UEC flow.

Advise:

- The lead Directors attended the Committee to present their CIP plans for 23/24. They explained the current position of CIPs against target, how gaps would be filled and by when and how CIPs would be monitored and controlled during the year. Of the Total CIP required of £27.5m, £23m had been identified. The shortfall of £4.5m had reduced slightly by the time of the meeting and work was ongoing. The largest gap was in

unplanned care and although work was ongoing the gap would be difficult to close. Risks and controls around the CIP programme were noted.

- Capital expenditure at month 12 was £17.96m against a plan of £18.20m. Expenditure was therefore slightly lower than the Capital Resource Limit.
- Following a review PDC of approximately £1.8m was returned for digital schemes in 2022/23. The potential impact of the change in accounting treatment is being assessed as part of the capital planning for 2023/24
- The two recent periods of junior doctors' industrial action have resulted in reduced activity due to cancelled appointments and incurred a cost pressure of approximately £800k.
- The progress of all the workstreams in the Surgical pathway programme was presented. The programme is performing well against national benchmarking and the Trust's peers. The review has identified opportunities for efficiency improvements in line with ERP and CIP plans including a stronger focus on average cases per theatre list. Next steps and key risks were noted. The Committee were informed there will be a Perfect Week in June and executives were encouraged to attend.
- The Terms of Reference were approved subject to an amendment to the members to be present for the meeting to be quorate.

Assurance:

- Plans were provided showing the actions to be taken and progress to date with medical recruitment plans including the replacing of locum/agency staff with substantive posts to mitigate the cost of the payrate review. The 5 areas to address were discussed together with the need to develop a mechanism to pull together the savings so that they can be clearly identified and utilised as planned.
- An update was provided on current work underway within ENH HCP. This included establishing a new target operating model for delivery and development requirements for 23/24.
- A ENH HCP transformation update was presented including good progress on Hospital at Home, the selection of ENH HCP as an accelerator site for managing heart failure at home and the establishment of a new HCP learning network.

Important items to come back to committee (items committee keeping an eye on):

None

Items referred to the Board or a committee for a decision/action:

None

Recommendation	The Board is asked to note the Finance, Performance and Planning report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	17
Report title	Quality and Safety Committee 29 March 2023 highlight report	**Meeting Date**	3 May 2023
Chair	Dr Peter Carter - Committee Chair and Non-Executive Director		
Author	Julia Smith – Assistant Trust Secretary		
Quorate	**Yes** ☒	**No** ☐	

Agenda:

- Quality Improvement Service Overview
- Risk Management Update
- Board Assurance Framework
- Committee Effectiveness, Terms of Reference and Annual Cycle Review
- Quality and Safety Month 11 Report
- Daily Improvement Drivers for Fundamentals of Care
- Safer Staffing Report
- Learning from Deaths Report
- Maternity Assurance Reports
- Audiology National Alert Response
- Quality and Safety Escalation Reports

Alert:

- A high number of risks are still to be reviewed.
- Risks remain around the timelines and documenting of 4hour observations.
- The Trust is an outlier for c.difficile across the System with a total of 66 cases against a threshold of 59.
- An uplift in nursing establishment had been identified and put into the budget setting process.
- There were risks around minimum safe staff standards with care hours per patient day in the lower quartile.

Advise:

- There were a number of issues with the transition to ENHance which are scheduled to be completed by 30 March 2023.
- The Clinical Engagement risk remained high and had not been updated due to the impact of the Junior Doctors industrial action.
- Membership of the committee to be reviewed to include finance, operations and patient representation.
- A review of Gynaecology Oncology for the treatment of women with Gynaecological cancer had been completed and initial findings received. Work was underway on the communication of the messages.
- High visibility boards would provide a direct line of sight of key markers against the fundamentals of care.
- Bed modelling for 2023 remained unclear which posed establishment challenges.
- A training package was being developed to support the early identification of carers.

The overall vacancy rate for midwifery is 33WTE. The medical sickness rate is 8% with plans in-place to mitigate and support, whilst 8% is an improvement it is still a matter of concern.

Assurance:

- The Quality Improvement team had 57 programmes underway with 10% of the organisation, the expectation is this will increase to the 25% target with the single improvement partner.
- The implementation of the maternity triage process was operational from 14th March 2023.
- The changes for the VTE risk assessment had been implemented with a weekly review and increased visibility.
- Crude mortality indicator remained well positioned against the national position.
- The data regarding the MRSA bacteraemia in the IPR was incorrect and there had only been one case.
- The maternity assurance report highlighted:
    - Positive trajectory to achieve 90% compliance for safeguarding level 3 training before the next CQC submission deadline
    - Significant improvement for medicines management training
    - Trajectory in place for the new Grow Together window
    - Shift plan close to completion for all inpatient areas
    - All areas highlighted in the Ockenden and East Kent reports were being worked on

Important items to come back to committee (items committee keeping an eye on):

Items referred to the Board or a committee for a decision/action:

Recommendation	The Board is asked to **NOTE** the Quality and Safety Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	17
Report title	Quality and Safety Committee 26 April 2023 highlight report			**Meeting Date**	3 May 2023
Chair	Dr Peter Carter - Committee Chair and Non-Executive Director				
Author	Julia Smith – Assistant Trust Secretary				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Paediatric Services Risks and Issues
- Combined Compliance and Risk Report
- Board Assurance Framework
- Terms of Reference – Membership
- Quality and Safety Month 12 Report
- Quality Strategy Objectives Assurances
- Clinical Harm Review Update
- Strategic Food Review
- Maternity Assurance Report
- Maternity Bereavement
- ENHT Response to Endoscopy
- Q4 Complaints and Patient Experience Report

Alert:

- High risks within Paediatric services include nursing and consultant staffing, discharge summaries, aged ventilators in use and delays in ADHD medication reviews. All risks are being mitigated and escalated but they are affecting the service.
- Issues remain around the infection prevention and control quality assurance visits with a lack of accountability from the staff in relation to issues within their control.
- There has been an increase in the number of patients requiring a clinical harm review due to low numbers being completed.
- PALS enquiries increased in the quarter with main themes being delayed follow-up and outpatient appointments and communication with medical staff. Support is being provided to the team daily.
- The water safety authorised person has reported slightly higher than expected levels of Legionella in areas at Mount Vernon Cancer Care. Point of use filters have been installed and works are being planned to maintain the filtration system along with new sinks and taps.

Advise:

- Children's services have made an application for a CNS to the Roald Dahl fund, feedback is expected in the coming week.
- The number of overdue risks has increased to 633. Service level support is being implemented and risk training is being carried out.
- The new ENHance system roll-out is continuing and use of the system evolving, there are challenges with extracting the data, but work is progressing.

- Water safety, ventilation and contamination are areas of concern and a deep dive has been organised to produce assurance with the actions and mitigations in place.
- Validation of maternity training and appraisals is underway while work on the digital systems continues. There is evidence of compliance and the completion of the digital work will provide assurance.
- Medical workforce in the Women and Children's division remains pressured. A consultant post is being recruited to and shifts continue to be back filled with locum staff.
- The action plans for improvement in the Endoscopy unit are underway and the team are in an improved position which will continue. The actions include work with GPs to improve referrals, consultants reviewing waiting lists as well as an education and culture programme for all staff

Assurance:

- Structured mock inspections are being implemented across the Trust, these are being run with internal teams and the ICB.
- Work is underway on a strategic food review with the public health registrar. The ambition is to provide healthier, cheaper, and easily accessible food and drink to staff and visitors. This will also achieve the new national food standards implemented by NHS England.
- Maternity vacancy rate has improved to 13.7% with23 band 5 positions having been accepted.

Important items to come back to committee (items committee keeping an eye on):

- Water safety, ventilation, and contamination
- Clinical Harm reviews
- Discharge summaries

Items referred to the Board or a committee for a decision/action:

Recommendation	The Board is asked to **NOTE** the Quality and Safety Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	18
Report title	Audit & Risk Committee 3 April 2023 highlights report		**Meeting Date**	3 May 2023
Chair	Jonathan Silver - Audit & Risk Committee Chair and Non-Executive Director			
Author	Julia Smith – Assistant Trust Secretary			
Quorate	**Yes**	☒	**No**	☐

Agenda:

- Summary Internal Controls Assurance Report
- Draft Internal Report and Head of Internal Audit Opinion
- Internal Audit Plan
- Internal Audit Action Tracker
  - Medical Director's Office Audit Assurance
- Anti-Crime Progress Report
  - Anti-Crime Plan 2023/24
- External Audit Plan 2023/24
- Risk Management Update
  - Risks 20+ update
- Board Assurance Framework Deep Dive
- Review of Standing Orders and Standing Financial Instructions
- Committee Effectiveness, Terms of Reference, and Annual Cycle Review
- Quality Account Timeline to Completion
- Cyber Security Report
- Data Quality and Clinical Coding Report

Alert:

- The deadline for issuing External Audit opinion is 30th June 2023 and BDO expect to complete in a timely manner. There was no interim status available due to the revised standards requiring every balance to be risk assessed.
- A section 30 will be issues to the Trust for breach of the break-even duty and the details of this will be confirmed.
- The committee discussed the Standing Orders and Standing Financial Instruction review and agreed more work was required to ensure they were specific to the Trust. The committee were happy to endorse for Board approval subject to the required changes being made.
- There were no details of the digital risks and mitigations included within the digital report.

Advise:

- Referral to Treatment internal audit received a limited assurance, this was in part due to the reduction in WLI's. A plan for high level elective activity will be presented to the Trust Board for approval in due course.
- The draft discharge summaries report was issued based on incorrect data provided. The correct data will need to be identified and may require additional audit time.
- The Anti-Crime plan for 2023/24 was approved by the committee.

• Under the new external audit standard, new risks had been identified. • The committee recognised the improvement to the BAF, but concern was raised regarding the triangulation of risks through the committees and the risk mitigation. • The Quality Account timeline was noted as 20th June 2023 with no extraordinary areas highlighted.
Assurance:
• The draft Head of internal Audit opinion provided reasonable assurance. This is not expected to change unless any significant issues emerge which is unlikely as key areas are reasonable. • The number of risks rated at 20+ had reduced to 26 which was a significant improvement • MC assured the committee that the use of the 42-week tracker ensures that staff delivered against their job plan and although most consultants over delivered against plan, the requirement was for all to adhere to the standards. Good progress had been made on the implementation of the new system • The committee approved the effectiveness review, terms of reference and annual cycle for 2023/24.
Important items to come back to committee (items committee keeping an eye on):
• Consultant job planning • Final Head of Internal Audit Opinion • External Audit Report • Digital risks
Items referred to the Board or a committee for a decision/action:
N/A

Recommendation	The Board is asked to **NOTE** the Extraordinary Audit Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	19
Report title	People Committee 18 April 2023 highlight report			**Meeting Date**	3 May 2023
Chair	Val Moore – Committee Chair and Non-Executive Director				
Author	Debbie Collins – Corporate Governance Officer				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Annual Cycle
- Terms of Reference
- People Strategy Progress Report
- Workforce Plan
- Trust Wide Staff Survey
- Resourcing Update
- Model Employer / Inclusive Recruitment
- Equality Delivery Standards 23/24
- Junior Doctor Contract Update
- Board Assurance Framework

Alert:

- There has been an increase in workforce in the last year.
- The Grow Together discussion compliance rates remain low. This will be addressed through divisional board meetings and a focus on accountability.
- There will be a significant CIP requirement over the next year along with a reduction in WTEs.
- There remains an under representation of black, Asian and ethnic minority, specifically at senior level.

Advise:

- The People Committee will take place six times per year instead of five times per year from 2024.
- A values refresh has taken place with a framework for individual team charters. Phase 2 has commenced, which will focus on accountability.
- Reciprocal mentoring has started to take place.
- Vacancy rates have increased over the last 12 months. However, turnover has reduced.
- The Trust has been asked to complete domain one of the Equality Delivery Standards 23/24. This was previously carried out at ICS level.
- The Board Assurance Framework for the People Committee will remain at a score of 16.

Assurance:

- There is a plan to reduce the vacancy rate to 5% and to reduce reliance on bank and temporary staff by increasing substantive staff.
- There will be an emphasis on induction and onboarding to ensure candidates receive a better experience.
- More staff have completed the annual staff survey this year compared to previous years.
- There has been a growth in under-represented staff groups at bands 5, 6, 7 and 8A.
- Recruitment processes will be reviewed to ensure there is no bias.

Important items to come back to committee (items committee keeping an eye on):

- A reduction in the use of temporary and bank staff and an increase in WTEs.

Items referred to the Board or a committee for a decision/action:

None

Recommendation	The Board is asked to note the People Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	20
Report title	Charity Trustee Committee 6 March 2023 Highlight Report	**Meeting Date**	3 May 2023
Chair	Dr David Buckle – Committee Chair and Non-Executive Director		
Author	Debbie Collins – Corporate Governance Officer		
Quorate	**Yes** ☒	**No** ☐	

Agenda:

- Charity Finance Report
- Approval of Budgets and Forecast
- Charity Highlight Report
- Major Project Update
- Investment Portfolio Report
- Taking back gains from Investment Portfolio
- Approvals in Excess of £5,000

Alert:

- There had been an increase in audit costs, and this was being looked into by the Director of Finance.
- Investment Portfolio – the quarterly performance of the fund was slightly below the benchmarked position.
- Taking back gains from Investment Portfolio – if substantial money is not received within the next month, it will be necessary to draw down on investment funds.

Advise:

- The Committee **approved** the following applications over £5,000:

Area	Project	Cost
MVCC Cancer Services	Establish a twelve-month project in conjunction with Cancer Hair Care Services.	£13,440
MVCC Cancer Services	Three CADD Solis infusion pumps with backpack and charger accessories.	£8,240
Corporate Staff Awards	Venue hire for staff awards. It was hoped the entire costs would be sponsored and therefore the Charity would not need to pay for this.	£16,800
MVCC Cancer Services	Specialist software for MRI radiotherapy planning which would eliminate the need for patients to have an additional CT scan on top of their MRI scan.	£14,000
MVCC Cancer Services	Purchase of an EPISCAN to aid planning of non-melanoma skin cancer patients.	£19,000
Research and Development •	Rental match funding to enhance better research into renal disease.	£19,950

- The Committee **did not approve** the following application:

MVCC Cancer Services	Resilience training for staff at MVCC was not approved by the Committee.	£14,650 + £1,900

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- Charity Finance Report Month 10 – it was noted that the income for month 10 was slightly below budget and expenditure was slightly higher than budget. Historically there has been an increase in legacy income in month 12 and the same was expected for this year. The team have been following up on outstanding legacies. Overall, the balance sheet looked healthy.
- Major Project Update - the Committee were updated with two options for the Sunshine Appeal space with the preferred option being the one where the space would extend from ITU. The Committee **approved** this to be taken to the next phase.
- The Committee were advised that Cura provide hardship grants to individuals with breast cancer and are winding down their business and would like to give the Charity £40k.
- A development session will be set up in October 2023 to discuss the Committee's purpose and how to promote the Charity.

Assurance:

- The Committee approved the budgets and forecast.
- Charity Highlight Report – the Committee were assured by the activities of the charity team and that a new customer relationship programme would be going live from April which would aid being able to contact people directly.

Important items to come back to committee (items committee keeping an eye on):

None.

Items referred to the Board or a committee for a decision/action:

None.

Recommendation	The Board is asked to note the Charity Trustee Committee report

Board Annual Cycle 2023-24

Notes regarding the annual cycle:

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

Items	5 April 2023	3 May 2023	7 June 2023	5 Jul 2023	Aug 2023	6 Sept 2023	4 Oct 2023	1 Nov 2023	6 Dec 2023	Jan 2024	Feb 2024	Mar 2024
Standing Items												
Chief Executive's Report		X		X		X		X		X		X
Integrated Performance Report		X		X		X		X		X		X
Board Assurance Framework		X		X		X		X		X		X
Data Pack		X		X		X		X		X		X
Patient Testimony (Part 1 where possible)		X		X		X		X		X		X
Employee relations (Part 2)		X		X		X		X		X		X
Board Committee Summary Reports												
Audit Committee Report		X		X		X		X				X
Charity Trustee Committee Report		X		X				X		X		
Finance, Performance and Planning Committee Report		X		X		X		X		X		X
Quality and Safety Committee Report		X		X		X		X		X		X
People Committee		X		X		X		X		X		X
Strategy												
Planning guidance										X		
Trust Strategy refresh and annual objectives										X		
Strategic transformation update				X				X				X
Integrated Business Plan						X						
Annual budget/financial plan		X										
Long-term strategic infrastructure						X						X
Digital Strategy Update				X								

Board Annual Cycle 2023-24

Items	5 April 2023	3 May 2023	7 June 2023	5 Jul 2023	Aug 2023	6 Sept 2023	4 Oct 2023	1 Nov 2023	6 Dec 2023	Jan 2024	Feb 2024	Mar 2024
System Working & Provider Collaboration (ICS and HCP) Updates		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update (Part 2)		X		X		X		X		X		X
Communication and Engagement		X										
Estates and Green Plan								X				
Equality, Diversity and Inclusion										X		
Clinical and Quality Strategies												X
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report – Approval Process		X										
Value for Money Report						X						
Audit Committee TOR and Annual Report				X								
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
Finance, Performance and Planning Committee												
Finance Update (IPR)		X		X		X		X		X		X
FPPC TOR and Annual Report				X								
Quality and Safety Committee												
Complaints, PALS and Patient Experience Report		X				X				X		

Board Annual Cycle 2023-24

Items	5 April 2023	3 May 2023	7 June 2023	5 Jul 2023	Aug 2023	6 Sept 2023	4 Oct 2023	1 Nov 2023	6 Dec 2023	Jan 2024	Feb 2024	Mar 2024
Safeguarding and L.D. Annual Report (Adult and Children)				X								
Staff Survey Results		X										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								
People Committee & Culture												
People & workforce strategy annual progress report										X		
Trust Values refresh				X								
Freedom to Speak Up Annual Report								X				
Staff Survey Results		X										
Equality and Diversity Annual Report and WRES						X						
Gender Pay Gap Report		X										
People Committee TOR and Annual Report								X				
Shareholder / Formal Contracts												
ENH Pharma (Part 2) shareholder report to Board				X								