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The meeting of the Board of Directors held in public will take place on
Wednesday 26 October 2016 in the Boardroom, Harrogate District Hospital,
 Lancaster Park Road, Harrogate, HG2 7SX
Start: 9.00am Finish: 12.15pm

AGENDA			
Item No.	Item	Lead	Paper No.
8.30am Patient Story – IN PRIVATE			
9.00am – 11.00am			
Clinical Transformation Board Update		Mr J Coulter, Deputy Chief Executive/ Finance Director	-
1.0	Welcome and Apologies for Absence <i>To receive any apologies for absence</i>	Mrs S Dodson, Chairman	-
2.0	Declarations of Interest and Register of Interests <i>To declare any interests relevant to the agenda and to receive any changes to the register of interests</i>	Mrs S Dodson, Chairman	2.0
3.0	Minutes of the Board of Directors meeting held on 28 September 2016 <i>To review and approve the minutes</i>	Mrs S Dodson, Chairman	3.0
4.0	Review Action Log and Matters Arising <i>To provide updates on progress of actions</i>	Mrs S Dodson, Chairman	4.0
Overview by the Chairman		Mrs S Dodson, Chairman	-
5.0	Strategic Key Performance Indicators – quarterly report <i>To approve the new format for comment</i>	Dr R Tolcher, Chief Executive	5.0
6.0	Report by the Chief Executive <i>To receive the report for comment</i>	Dr R Tolcher, Chief Executive	6.0
7.0	Integrated Board Report <i>To receive the report for comment</i>	Dr R Tolcher, Chief Executive	7.0
8.0	Report by the Finance Director <i>To approve the Q2 Financial Sustainability Risk Rating of 4 to NHS Improvement</i>	Mr J Coulter, Deputy Chief Executive/ Finance Director	8.0
8.1	Operational Planning 2017/18 and 2018/19 <i>To be considered for comment and approve the Control Total offer</i>	Mr J Coulter, Deputy Chief Executive/ Finance Director	8.1
9.0	Report from the Chief Operating Officer <i>To approve the Q2 Governance section of the Risk Assessment Framework as Green for submission to NHS Improvement</i>	Mr R Harrison, Chief Operating Officer	9.0

11.00am – 11.10am – Break			
11.10am – 12.15pm			
10.0	Report from the Chief Nurse <i>To receive the report for comment</i>	Mrs J Foster, Chief Nurse	10.0
11.0	Report from the Medical Director <i>To be considered for comment</i>	Dr D Scullion, Medical Director	11.0
12.0	Report by the Director of Workforce and Organisational Development <i>To receive the report for comment</i>	Mr P Marshall, Director of Workforce & Organisational Development	12.0
13.0	Oral Reports from Directorates 13.1 <i>Long Term and Unscheduled Care</i> 13.2 <i>Planned and Surgical Care</i> 13.3 <i>Children's and County Wide Community Care</i>	Mr A Alldred, Clinical Director Dr K Johnson, Clinical Director Dr N Lyth, Clinical Director	- - -
14.0	Committee Chair Reports 14.1 <i>To receive the report from the Quality Committee meeting held 5 October 2016</i> 14.2 <i>To receive the report from the Finance Committee meeting held 19 October 2016</i>	Mrs L Webster, Non-Executive Director/ Quality Committee Chair Mrs Maureen Taylor, Non-Executive Director/ Finance Committee Chair	14.1 14.2
15.0	Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators <i>To receive an update on any matters of compliance:</i> 15.1 <i>To approve the Standing Financial Instructions and Standing Orders</i>	Mr J Coulter, Deputy Chief Executive/ Finance Director	15.1
16.0	Any other relevant business not included on the agenda <i>By permission of the Chairman</i>	Mrs S Dodson, Chairman	-
	Board Evaluation	Mrs S Dodson, Chairman	-
Confidential Motion – the Chairman to move: <i>Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.</i>			

BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

This is the current register of the Board of Directors of Harrogate and District Foundation Trust and their declared interests.

The register is maintained by the Foundation Trust Office.

Name	Position	Interests Declared
Mrs Sandra Dodson	Chairman	<ol style="list-style-type: none"> 1. Partner in Oakgate Consultants 2. Trustee of Masiphumelele Trust Ltd (a charity raising funds for a South African Township) 3. Trustee of Yorkshire Cancer Research 4. Chair of Red Kite Learning Trust – multi-academy Trust
Dr Ros Tolcher	Chief Executive	<ol style="list-style-type: none"> 1. Specialist Adviser to the Care Quality Commission 2. Member of NHS Employers Policy Board
Mr Jonathan Coulter	Deputy Chief Executive/ Finance Director	None
Mrs Jill Foster	Chief Nurse	None
Mr Robert Harrison	Chief Operating Officer	<ol style="list-style-type: none"> 1. Appointed Voluntary Member of the Strategy and Resources Committee of the Methodist Church 2. Charity Trustee of Acomb Methodist Church, York
Mr Phillip Marshall	Director of Workforce and Organisational Development	<ol style="list-style-type: none"> 1. Member of the Local Education and Training Board (LETB) for the North
Mr Neil McLean	Non-Executive Director	Director of: <ul style="list-style-type: none"> - Northern Consortium UK Limited (Chairman) - Ahead Partnership (Holdings) Limited - Ahead Partnership Limited - Swinsty Fold Management Company Limited - Acumen for Enterprise Limited - Yorkshire Campaign Board Chair Maggie's Cancer Caring Centres Limited
Professor Sue Proctor	Non-Executive Director	<ol style="list-style-type: none"> 1. Director and owner of SR Proctor Consulting Ltd 2. Chair, Safeguarding Board, Diocese of York 3. Member – Council of NHS Staff College (UCLH) 4. Associate – Good Governance Institute 5. Associate – Capsticks
Dr David Scullion	Medical Director	<ol style="list-style-type: none"> 1. Member of the Yorkshire Radiology Group

Mrs Maureen Taylor	Non-Executive Director	None
Mr Christopher Thompson	Non-Executive Director	1. Director – Neville Holt Opera 2. Member – Council of the University of York
Mr Ian Ward	Non-Executive Director	1. Vice Chairman and Senior Independent Director of Charter Court Financial Services Limited, Charter Court Financial Services Group Limited, Exact Mortgage Experts Limited, Broadlands Financial Limited and Charter Mortgages Limited 2. Chairman of the Board Risk Committee and a member of the Remuneration and Nominations Committee, the Audit Committee and the Funding Contingent Committee for the organisations shown at 1 above 3. Director of Newcastle Building Society, and of its wholly owned subsidiary IT company – Newcastle Systems Management Limited 4. Member, Leeds Kirkgate Market Management Board
Mrs Lesley Webster	Non-Executive Director	None
Mr Andrew Alldred	Clinical Director UCCC	None
Dr Kat Johnson	Clinical Director EC	None
Dr Natalie Lyth	Clinical Director IC	None
Dr David Earl	Deputy Medical Director	1. Private anaesthetic work at BMI Duchy hospital
Dr Claire Hall	Deputy Medical Director	1. Trustee, St Michael's Hospice Harrogate
Mrs Joanne Harrison	Deputy Director W & OD	None
Mr Jordan McKie	Deputy Director	1. Familial relationship with NMU Ltd, a company providing services to the NHS
Mrs Alison Mayfield	Deputy Chief Nurse	None
Mr Paul Nicholas	Deputy Director Performance and Infomatics	None

October 2016

Report Status: Open**BOARD OF DIRECTORS MEETING**

Minutes of the Board of Directors meeting held in public on Wednesday 28 September 2016
8.30am in the Boardroom, Trust Headquarters, Harrogate District Hospital

Present: Mrs Sandra Dodson, Chairman
Dr Ros Tolcher, Chief Executive
Mr Jonathan Coulter, Deputy Chief Executive/Finance Director
Mr Rob Harrison, Chief Operating Officer
Mrs Jill Foster, Chief Nurse
Dr David Scullion, Medical Director
Mr Phillip Marshall, Director of Workforce and Organisational Development
Professor Sue Proctor, Non-Executive Director
Mr Neil McLean, Non-Executive Director
Mr Chris Thompson, Non-Executive Director
Mr Ian Ward, Non-Executive Director
Mrs Lesley Webster, Non-Executive Director

In attendance: Ms Debbie Henderson, Company Secretary
Mr Andrew Alldred, Clinical Director for Long Term and Unscheduled Care
Dr Kat Johnson, Clinical Director for Planned and Surgical Care
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services
Mr Richard Chillery, Operational Director for Children's and County Wide Community Services
Mr David Plews, Deputy Director of Partnerships and Innovation (*Board briefing only*)
Mrs Sarah Massiter, Clinical Lead for Health Visiting and School Nursing – *Patient Story only*
Mrs Alexandra Eley, Health Visitor – *Patient Story only*
Dr Claire Hall, Deputy Medical Director

Patient Story

Mrs Massiter and Mrs Eley presented the patient story based on a case study describing the impact of using the Home Environment Checklist, particularly in terms of the positive impact and outcomes for the lives of children in the community setting.

On behalf of the Board, Mrs Dodson and Dr Tolcher thanked Mrs Massiter and Mrs Eley for taking the time to share their story with the Board. The Board acknowledged their courage and fortitude in dealing with such emotive and challenging situations, and applauded their professionalism and tenacity in supporting and safeguarding vulnerable children.

Dr Tolcher, Mrs Massiter and Mrs Eley took an opportunity to discuss the important role of Health Visitors and School Nurses and noted the increasing reliance on Health Visitors in terms of highlighting issues within social services. Mrs Massiter stated that case studies were being shared with CCG colleagues to promote the importance of the service.

Mr Harrison confirmed that lone working devices had been implemented to ensure the safety of Trust staff within the community setting.

Board Briefing – Rapid Process Improvement Workshop

Mr Plews provided an update for the Board on the ‘urology cancer pathway improvement project’ and the ‘enhancing the surgical pathway project’.

A rapid process improvement workshop had been held in early May to focus on expediting patients through the first part of the urology cancer pathway, from referral to treatment/surveillance/ discharge/transfer. Mr Plews confirmed that re-measuring was taking place to ascertain whether the stretching target of reducing this part of the pathway from 38 days to 27 had been successful. Anecdotal evidence suggested improvements were moving patients in the right direction towards the target. Improved scheduling of MRI scans, increased telephone interaction with patients and improved patient information were helping to secure further improvements.

A rapid process improvement workshop was held in June to look at improving patient flow on the day of surgery and re-measurement work had commenced to ascertain if key targets had been met. A trial to standardise the point at which patients were called for the next procedure had been successful. Provision of additional training for Care Support Workers to be involved in accompanying patients back to the ward from the theatre complex had helped to minimise queuing in recovery. A business case to reverse the use of Farndale and Wensleydale wards was under consideration and next steps included further work on making improvements to scheduling in order to further optimise theatre productivity.

Mrs Dodson stated that the incremental changes evident within the rapid process improvement work were fundamental to leading to transformational change. Dr Tolcher stated she continued to be impressed with the commitment from Mr Plews and individual teams to drive forward change, by supporting the Trust’s ‘You Matter Most’ pledge.

1. Welcome and Apologies for Absence

No apologies for absence had been received. Reflecting on the patient story and the Board briefing on Rapid Process Improvement Workshops, Mrs Dodson took an opportunity to acknowledge the high professionalism, compassion and dedication of HDFT staff members, as well as the quality of internal work to continually improve services and use of resources within the Trust.

Mrs Dodson welcomed to the meeting two Governors, Mr Richard Chillery, the newly appointed Operational Director for the Children’s and County Wide Community Services directorate, Dr Claire Hall, Deputy Medical Director, and one member of the public.

2. Declarations of Interest and Board Register of Interests

Dr Tolcher noted her recent appointment on the NHS Employers Policy Board, responsible for setting national policy for employment. Dr Tolcher made particular reference to the request that she act as the Chief Executive representative on the Policy Board on behalf of NHS Providers.

Mr Marshall referred to his acceptance of the role on the newly established Local Education and Training Board (LETB) for the North. The role would initially be for a 12 month period with a commitment of one day per month.

Professor Proctor asked the Board to note that she had stepped down from her role on the Council of Leeds University.

All appropriate amendments would be made to the register of interests. There were no further declarations of interest relevant to items on the agenda.

3. Minutes of the meetings of the Board of Directors on 27 July 2016

The draft minutes of the meeting held 27 July 2016 were accepted as a true record, subject to the following amendments;

Page 3 – item 4.4 – include ‘*consideration*’ of the introduction of annualised job plans.

Page 13 – item 12.1.1 – remove ‘*corporate*’.

APPROVED:

- **The Board of Directors approved the minutes of the meeting held 27 July 2016 as an accurate record of proceedings subject to the amendments detailed in the minutes**

4. Review of Action Log and Matters Arising

4.1 With regard to item 1, Dr Lyth referred to the key performance indicators (KPIs) which had been included in the Integrated Board Report (IBR), and advised that a larger piece of work would be undertaken over the next six months to ensure KPIs across all services would be captured to provide appropriate visibility at Board level. Mr Harrison confirmed that following the development of the new dashboard for the Children’s and County Wide Community Services directorate, relevant metrics would be included in the IBR.

4.2 With regard to item 2, Mr Coulter confirmed that there would be no contractual penalties associated with the absence of a threshold target for new birth visits by Health Visiting Teams within 14 days of birth. It was agreed to record the action as complete.

4.3 An update with regard item 3 would be provided under agenda item 13 – Oral Report from Directorates. It was agreed to record the item as complete.

4.4 An update with regard to item 4 would be provided under agenda item 10, Chief Nurse Report. It was agreed to record the item as complete.

Overview by the Chairman

Mrs Dodson outlined the overarching themes for the meeting, as identified by the Non-Executive Directors to include; impact of the external NHS agenda on the business of the Trust, particularly with regard to Sustainability and Transformation Planning (STPs), the implications of the Single Oversight Framework and Vanguard work on New Care Models with partners; operational issues relating to activity and financial performance; and workforce and ensuring staff have the ability and capacity to undertake the work required to continue to deliver high quality care.

5. HDFT Mission and Objectives

The report had been circulated in advance of the meeting and was taken as read.

5.1 Dr Tolcher referred to the proposal to amend the narrative of the Trust's vision, mission and objectives to reflect the Trust's responsibilities regarding the wider public health agenda and making 'every contact count' in terms of health, care and prevention. Dr Tolcher had met with Public Health Directors and the need to reflect the change in the Trust's profile was acknowledged.

5.2 Mr Thompson referred to the strategic objectives and asked if specific reference to end of life care should be made. Dr Tolcher noted that end of life care was already integral to HDFT's existing framework.

5.3 Following a suggestion from Mrs Webster, it was agreed to amend the term '*endeavour*' to '*strive*'.

5.4 Dr Lyth expressed thanks to the Board for reflecting the importance of public health and the way in which the document had been 'track changed' to clearly show the amendments proposed. It was agreed to ensure that any future documents presented to the Board which were predicated on changes be presented in a similar way.

5.5 Dr Tolcher also referred to a number of national programmes in which the Trust was participating including 'being a mindful employer' and the Trust's commitment to supporting the 'being a healthy hospital' programme.

APPROVAL:

- **The Board of Directors approved the revisions to the wording of the Trust's vision, mission and objectives subject to the amendment to change '*endeavour*' to '*strive*'**

6. Report by the Chief Executive

The report had been circulated in advance of the meeting and was taken as read.

6.1 Dr Tolcher provided an update on the contract position for 2016/17 and noted that the Trust had transitioned to the new Community Services specification, which was aligned to the roll out of the New Care Model across Harrogate and Rural District, and noted that the financial run rate now reflected the requirements of the new contract.

6.2 Dr Tolcher referred to a discussion with Professor Sir Mike Richards of the Care Quality Commission (CQC) regarding the Trust's 'Good' rating overall and next steps. The CQC had now undertaken inspections of all Trust's and were making arrangements to move to their new inspection regime, and proposals for re-inspections and supporting continual improvement. Dr Tolcher proposed that the Trust be put forward as a pilot and discussed potential timescales and the actions that would be required to be ready for re-inspections under the new regime.

6.3 In terms of the Trust's year-to-date financial position, Dr Tolcher reported the position as £781k adverse of plan, and whilst noting some significant areas of improvement, confirmed that areas of challenge remained. The August meeting of the Senior Management Team had been dedicated to a discussion on the financial recovery plan to ensure confidence in achievement of the Trust's control total at the end of the year. There remained areas of shortfalls in income and each directorate had implemented recovery plans to address the areas of challenge. With regard to the Cost Improvement Plan, the risk adjusted plan total stood at 95%. The Senior Management Team particularly focused on staff overspend and work had commenced to review bed numbers and ward establishments.

6.4 Dr Tolcher referred to the Board Assurance Framework (BAF) and advised that all actions had progress scores of 1 or 2 demonstrating ongoing focus and achievement of actions. The Board noted that following a review, four strategic risks had resulted in a reduction in risk scores in line with target risk scores and on that basis, Dr Tolcher recommended that BAF risk references 6, 7, 8 and 11 be de-escalated and removed from the BAF as all controls had been met.

6.5 The Board also noted one new BAF entry (BAF risk reference 16) regarding critical infrastructure, following a discussion at the July Board meeting regarding legionella testing. Dr Tolcher emphasised that this did not reflect a previously unrecognised risk, but provided increased visibility to the management of risks associated with critical infrastructure.

6.6 Mr Ward referred to the decrease in income from activity and asked for a realistic forecast for the remainder of the year. Mr Coulter referred to the ongoing work to review bed numbers and establishments in light of activity planning, particularly around planned and surgical care. Mr Harrison stated that the work would be risk adjusted to provide a realistic forecast and noted the highest risk area as gastroenterology, particularly in terms of high volume endoscopy and outpatients. Mr Harrison noted a high use of locums and capacity issues within the service and noted the return of a consultant following sabbatical, and a further locum in place from early October.

6.7 Mr Harrison also referred to the recent support provided by the Trust to Leeds Teaching Hospitals NHS Trust, particularly in Pathology. This support had not only resulted in a slight increase in income, but also provided capacity to treat patients following a number of elective cancellations in Leeds. In summary, Mr Harrison suggested that the actions identified in the recovery plans could mitigate some of the issues, but further work was required.

6.8 In response to Mr Ward's request for a realistic financial forecast, Mr Coulter confirmed that work had commenced at directorate level and would be included in the Finance Director's report at the October meeting of the Board.

6.9 Professor Proctor referred to the BAF and asked if the Board felt that the amendment to BAF 5: risk to sustainability of services, to incorporate Sustainability and Transformation Planning, was sufficient particularly in terms of senior leadership capacity. It was agreed to revisit the BAF to ensure that the risk relating to senior leadership capacity to deliver the current high number of strategic initiatives successfully had been reflected appropriately throughout the entire document.

6.10 Mrs Webster referred to the Community Contract and it was confirmed that although the financial element had been agreed and the associated financial risks mitigated, the contract had yet to be signed.

6.11 Mr Thompson referred to the agreement of financial run rates and expressed concern regarding the potential impact of the financial position of CCG on the Trust. The Board were reassured that dialogue with the CCG continued and would be taken into consideration in the planning process.

6.12 Mr Thompson referred to the Corporate Risk Register and risk number CR8: risk of harm to ophthalmology patients as a result of being lost to follow up, and raised concern at the lack of progress made. Dr Johnson confirmed that the key areas of risk related to the lack of qualified doctors to deliver the service and nursing staff had been engaged and responded positively to taking on additional roles. It was acknowledged that the lack of qualified doctors

had been recognised nationally, but Dr Johnson confirmed that the waiting list had reduced and approval of the new IT system for ophthalmology would support continual improvement.

6.13 Mr Coulter suggested that the risk reflected two issues: waiting lists and backlog; and a risk of people being lost to follow-up. With regard to the latter, Mr Harrison confirmed that a clear plan was in place which included data validation and RAG rated lists to prioritise patients based on clinical need. The IT system would allow the service to undertake virtual appointments for lower risk patients. It was agreed that a brief report be provided on progress at the January 2017 meeting of the Board.

6.14 Mrs Taylor asked for an update on the impact of the changes to the Community Services contract on the workforce. Dr Tolcher confirmed that the right run rate for the contract value had been achieved. The staff consultation process was ongoing but the workforce in place reflected the number of staff required to deliver the service and Dr Tolcher confirmed that there were no significant risks in this regard. Mr Marshall referred to discussions with Trade Union colleagues who had expressed their support and satisfaction with regard to the staff consultation process.

6.15 Dr Tolcher took an opportunity to remind Board colleagues of the background to Sustainability and Transformation Planning (STP) including an overview of Harrogate's position within the West Yorkshire STP footprint. Dr Tolcher recapped on the 'do nothing' and 'do something' scenarios and the respective financial gaps of both, and emphasised that the numbers assumed delivery of current year plans in full. It was acknowledged that there was a risk that the CCG financial position presented a risk to the system.

6.16 Dr Tolcher noted that there remained a substantial financial gap over the term of the West Yorkshire STP plan (WYSTP). As part of the development of the WYSTP, and the West Yorkshire Association of Acute Trusts (WYAAT) group's response to Jim Mackey's letter regarding sustainability of acute care and consolidation of back office functions, PWC was commissioned to deliver a project to help build the case for increased collaboration between the six acute trusts in the WYAAT group. Financial, quality and sustainability issues were reviewed to establish potential opportunities available through closer collaboration. This work would inform a more detailed analysis in those specialties where opportunities were apparent.

6.17 Other opportunities had been identified to support the work of the STP including: commissioner standardisation as a means to support demand management and reduced cost; repatriation of NHS work being delivered privately; exploring opportunities to expand and develop services further; and discharge management service and innovative solutions from the technology sector to improve productivity and impact on delayed transfers of care.

6.18 Dr Tolcher stated the importance of recognising that even if STPs did not exist, as a Trust, HDFT would be committed to closing the gaps over next five years. In terms of collaboration, discussions had commenced regarding the value of developing an alternative service delivery model with input from all acute trusts via a Committee in Common or a formally constituted entity. This would allow all parties to achieve efficiencies in a collaborative way whilst ensuring an appropriate distribution of risk/gain share. A further discussion would take place in the confidential Board session.

6.19 With regard to the impact of clinical networks as a business model proposition, WYAAT were exploring options to drive up quality and achieve 7-day services in an equitable way by delivering elective activity in designated centres in the region. It was acknowledged that such options may provide opportunities in terms of estate utilisation.

6.20 Dr Tolcher referred to the publication of NHS Operational Planning and Contracting Guidance 2017/18 and 2018/19 and the requirement to submit the final WYSTP by 21 October 2016. Prior to submission, information in response to NHS Improvement's request to consider opportunities to consolidate pathology services and back office functions would be submitted by Friday 14 October. Dr Tolcher also referred to regulator expectations to have agreed 2-year operational plans and associated contracts in place for 2017/18 and 2018/19 by 23 December. Provider and commissioner plans would be expected to align to overall STPs.

6.21 Dr Tolcher also referred to an expectation that although individual Trust's would remain responsible for delivery of organisational control totals, there may be circumstances whereby funding may be moved around within the STP system, if considered to help achieve the longer term vision. Therefore, the Trust's individual plan in terms of activity and workforce must support the STP plan to achieve an aggregate control total for the system.

6.22 Dr Tolcher referred to the draft Harrogate and Rural District STP plan and confirmed that the Board were not being asked to approve the plan, but were being asked to note it. Despite this, Dr Tolcher emphasised that the HDFT 2-year Operational Plan and associated contracts were required to align to the WYSTP. The WYSTP would be available on 21 October and would be submitted to a future Board meeting. Dr Tolcher emphasised the importance of ensuring openness and transparency in the public domain as far as possible.

6.23 Plans were in place for regulators to publish headline STP metrics in November 2016. Mr Coulter referred to the expectation that planning should be relatively straight forward due to the significant work already undertaken as part of sustainability and transformation planning, however, highlighted the current key financial risks in the local system which would influence the contractual discussions over the next few months.

6.24 From a governance perspective, Mrs Dodson referred to the Harrogate and Rural District STP and asked at what point the Board of Directors of HDFT would be required to approve the plan. Dr Tolcher confirmed that the Board were required to approve the Trust's 2-year Operational Plan for 2017/18 and 2018/19, and noted that there was no mandated requirement for individual provider/commissioner Boards to approve the WYSTP. Dr Tolcher noted that NHS commissioners had signalled that they had commenced discussions to explore integrated commissioning with North Yorkshire County Council. Work to date on an Alliance contract between partners in the Harrogate Vanguard had therefore stalled.

6.25 Mr Thompson referred to the Board's decision earlier in the year to approve the business case relating to the development the Electronic Patient Record and WebV and asked if the decision to approve the business case should be reconsidered in light of this change in stance. Mr Harrison confirmed that the decision taken was the right decision and it remained important to have in place an interoperable system with the ability to flex with other systems.

6.26 Mr McLean raised concern regarding the requirement of the Board to 'note' a plan, in terms of the responsibility of the Board to deliver it. Mr McLean referred to the Board's statutory responsibility and accountability to the Council of Governors and the local population. Mr McLean also raised concern regarding the level of pressure being exerted on the executive team by regulators to deliver new initiatives within unrealistic timescales and the potential adverse impact in terms of compromising their role of executive responsibility for the effective operations of the Trust. Mr McLean referred to the Board's responsibility for maintaining high quality care for the Trust and throughout West Yorkshire, and the need to avoid an imposed system which would be felt to be disadvantageous.

6.27 Mr McLean also raised concerns regarding the proposals for financial management within the STP footprint and the risk of low/adequate performance becoming the standard

across the patch. Mr McLean suggested that the concerns of the Board in this regard be escalated to the regulators in terms of the processes for governance around STPs being unacceptable to individual provider Boards.

6.28 Dr Tolcher accepted the concerns raised by Mr McLean and the Board agreed to undertake a more detailed discussion in private session. With regard to the time and effort which had been given to sustainability and transformation planning and noted the conscious decision to ensure HDFT remained engaged and influential with the system. The valuable work and contribution at deputy director level was acknowledged in terms of their support to the Executive Director team.

6.29 In terms of unacceptable workload and timescales, Dr Tolcher asked if Chairs and Non-Executive Directors could also raise their concerns at a regional and national level. Mrs Dodson confirmed that concerns had started to be raised via NHS Providers and agreed to write to Gill Morgan, NHS Providers Chair.

6.30 Professor Proctor endorsed the comments made by Mr McLean and referred to the risk relating to the implications of the Single Oversight Framework and the expectation of organisational autonomy being used to support poor performing organisations, and noted that again, these responsibilities fall outside the statutory responsibilities of Foundation Trusts. It was agreed to revisit, and ensure clarity and alignment, between the constitutional and legislative requirements of NHS organisations and new regulation and frameworks.

6.31 Professor Proctor also referred to the continuing lack of Non-Executive Director engagement in proposals, collaborations, initiatives and proposals for structural change and suggested that NED input could alleviate some of the concerns around leadership capacity and governance, as well as utilisation of a talent pool of NEDs across the system.

6.32 Dr Tolcher acknowledged the lack of involvement of Non-Executive Directors and recognition of Governors by Arm's Length Bodies, and suggested exploring options to develop a structure within the West Yorkshire system to take this forward. Dr Tolcher agreed to discuss NED involvement further with the WYAAT.

6.33 Mrs Dodson reminded members of the Board that a Board Strategy Day would take place on 10 October and would provide an opportunity to discuss collaboration and STPs further.

6.34 Dr Tolcher confirmed that West Yorkshire had been selected by the Secretary of State as the National Urgent and Emergency Care Acceleration Zone, the aim of which would be to deliver the 95% A&E 4-hour waiting time standard at West Yorkshire level by March 2017. Workstreams encompass: ambulance response times; mental health crisis and liaison; enhanced primary care; Emergency Department streaming; and improved discharge. Initial work had identified patient flow, attendance avoidance and Emergency Department capacity as priorities. Mr Harrison confirmed that a plan had been submitted requesting capital and revenue funding to support the proposed initiatives. It was also confirmed that there would be no penalties applied for not achieving the aggregate position.

6.35 In response to a query from Mrs Taylor regarding collaborative work to improve discharge planning, Mr Harrison briefed the Board on ongoing work with the industry for technology and health to explore opportunities and innovations to support community and acute teams including improving engagement of patients and families in the discharge planning process.

ACTION

- To include a 6-month financial forecast within the October Finance Director report
- Revisit the Board Assurance Framework to ensure adequate reflection of executive team capacity to delivery wider strategic initiatives
- Provide an update on progress with regard to actions associated with Corporate Risk Register CR8
- To write to Gill Morgan, Chair of NHS Providers to outline concerns regarding the impact on executive capacity to deliver large scale strategic change within unreasonable timescales

APPROVED:

- The Board of Directors approved the removal of the BAF risks 6, 7, 8 and 11 as all target scores had been met and actions delivered
- The Board of Directors approved the inclusion of BAF risk 16 to reflect risks associated with ensuring critical infrastructure

6.1 Harrogate and District Sustainability and Transformation Plan Update

The report had been circulated in advance of the meeting and was taken as read.

A discussion regarding the Harrogate and District Sustainability and Transformation Plan took place under agenda item 6.0 above.

7. Integrated Board Report (IBR)

The report had been circulated in advance of the meeting and was taken as read.

7.1 Mr Thompson referred to the variation of the Summary Hospital-level Mortality Indicator (SHMI) and Dr Scullion advised that there would be continual fluctuations related to the indicator over time, but provided reassurance that the Trust remained within the expected range.

7.2 Professor Proctor referred to mandatory training rates for staff transferred from County Durham, Darlington and Middlesbrough (CDDM) in April and noted that the Quality Committee continued to monitor compliance rates. Dr Lyth advised that members of staff had a clear understanding of the expectations related to training requirements and anticipated significant improvement going forward.

7.3 Mr Marshall stated that there had been no obligation for the transferring organisation to provide information on mandatory training compliance rates prior to TUPE transfer of staff. Mr McLean stated that any reasonable request for information could be made as part of any due diligence process. Mr Marshall agreed and confirmed that the Trust had been aware of the lack of information related to training compliance, but had not deemed the absence of the information as material to the success of the TUPE transfer. Mr Marshall also stated that CDDM data would be consolidated in the near future.

7.4 Mrs Webster referred to GP out of hours and stated that regular updates continued to be received by the Quality Committee but noted frustration that the narrative within the IBR did not reflect the significant level of activity to ensure a safe service is provided.

7.5 In terms of the Trust's consistency in upholding the agency cap, Mr Thompson raised concern regarding theatre utilisation and asked about flexibilities if the Trust was being significantly affected by our level of compliance with the agency cap. Mr Coulter provided clarity on the agency 'ceiling' and total agency spend, and stated that the Trust could employ

more agency staff within the capped agency rate. However, Mr Harrison noted that whilst there was a supply and demand issue, there remained a significant gap of Operating Department Practitioners within the system.

ACTION:

- **Narrative associate with GP out of hours to be improved to reflect the level of activity undertaken for future reports**

8. Report by the Director of Finance (including the quarterly Cost Improvement Plan update)

The report had been circulated in advance of the meeting and was taken as read.

8.1 Mr Coulter stated that no Sustainability and Transformation (S&T) funding had been assumed for July and August as a result of the Trust being behind the financial plan year to date. The drivers of adverse financial variance had been: elective activity levels; ward nursing expenditure; and achievement of the Cost Improvement Programme (CIP) to date. Mr Coulter stated that a discussion would take place with NHS Improvement regarding quarter 2 performance, and referred to the non-recurrent actions being undertaken to achieve performance against the plan, and achievement of S&T funding.

8.2 In terms of activity, the most challenging area was gastroenterology endoscopy however Mr Harrison had observed an increase in terms of elective in-patient activity.

8.3 Mr Coulter confirmed that a review of establishments and bed base moving into 2017/18 had commenced, particularly in response to initiatives such as the New Care Models work which had been funded for 2016/17. Mr Aldred emphasised the importance of the work in relation to bed numbers and establishments and the impact on delayed transfers of care and length of stay. The importance of aligning initiatives to ensure safe staffing with appropriate bed establishments, and ensuring strong community services to support Emergency Department performance, was acknowledged.

8.4 Professor Proctor referred to the expectations to agree a two-year operational plan and associated contracts and asked if there had been discussions at NHS England regarding a move from a block contract for community services, bearing in mind the vision of the NHS to provide care closer to home. Mr Coulter confirmed that discussions were taking place locally to scope a contract for 2017/18 which could include community services, medical non-elective activity, and minor injury unit attendances, with a principle of an agreed baseline to manage finances based on agreed demographics and efficiencies.

8.5 Mrs Taylor asked for an overview of the financial implications of decommissioning of the wheelchair service. Mr Coulter confirmed that the Trust would benefit financially from the decision not to bid for the contract as the Trust had significantly overspent on delivery of the service in order to manage and respond to demand. Mr Harrison noted that valuation of stock in terms of licenced assets had commenced. Mr McLean requested a further update at a future meeting.

8.6 With regard to the reduction in private patient activity, Mrs Dodson asked how private patient activity related to theatre capacity reduction in terms of staffing. Mr Harrison advised the Board that the private patient strategy was under development. Dr Johnson suggested that the reduction in private patient activity could be due to a lack of confidence by consultants related to nurse staffing in theatres. In response to a query from Mr Ward regarding use of agency staff, Mr Harrison reminded Board members of the decision to breach the cap to

support private patient activity where necessary. Dr Johnson reassured members of the Board that NHS elective patient activity had not been adversely impacted by private work.

8.7 Mrs Dodson asked when the Harlow Suite would re-open. Mr Harrison stated that it was the Trust's intention to re-open from mid-October.

ACTION:

- **Update on the risks associated with the wheelchair service to be provided at a future meeting of the Board**

9. Report from the Chief Operating Officer

The report had been circulated in advance of the meeting and was taken as read.

9.1 Mr Harrison confirmed that the Trust was on track to achieve the 95% A&E 4-hour waiting time standard for quarter 2.

9.2 Mrs Webster queried the Trust's position in terms of winter readiness. Mr Harrison confirmed that plans were in place which took into consideration historical performance. Profiling had been undertaken, supported by recovery plans, to establish bed requirements.

9.3 Dr Tolcher referred to the need for a step change in the rate of non-elective admissions, capacity for Emergency Department attenders, and impact of the response and overnight service in terms of the impact on the Trust's activity profiles.

10. Report from the Chief Nurse

The report had been circulated in advance of the meeting and was taken as read.

10.1 Mrs Foster provided an overview of: red rated areas following director inspections; actual versus planned staffing data; and nurse recruitment activity. As Chief Nurse, Mrs Foster reassured members of the Board that safe staffing levels had been maintained during July and August. Vacancies continued to be managed effectively, with increased oversight of key areas including Nidderdale ward and Farndale ward.

10.2 Mrs Taylor referred to the gaps in staffing but noted that Mr Coulter's report stated that the Trust had overspent on nursing establishments. Mrs Foster confirmed that gaps in staffing had been filled using agency staff and use of incentive payments for existing staff to undertake additional shifts. The incentive scheme would be terminated in November when a substantial number of new registered nurses commence employment. Mrs Foster also advised that requests for additional nursing staff had occasionally been due to a lack of confidence on the wards to deliver high quality care. Additional control and escalation processes had been implemented to manage requests for additional staff going forward.

10.3 Mrs Foster referred to the significant amount of work relating to e-rostering, but stated that further work was required to improve use of e-rostering in terms of training and development.

10.4 Mr Coulter stated that Care Support Workers had been used to cover gaps in Registered Nursing, particularly related to one-to-one special care requirements which had not been included in nursing establishments. Mrs Foster noted that work had commenced to understand this further including a review of the acuity tool and a request to the Trust's

Learning and Disability Lead to review the appropriateness and use of special one-to-one care requirements.

10.5 Mrs Taylor asked if the executive team were confident in the skills of the Matrons and Ward Managers to manage budgets. Mr Coulter advised that further training was required in some areas and it was acknowledged that a simple rostering process was required to support those with budgetary responsibility.

10.6 Mr Ward referred to director inspections and noted a sense of uncertainty from senior staff in terms of forward planning and asked if there had been some Rapid Process Improvement Work in this area. Dr Tolcher confirmed that the team had identified a disconnect between the budget owner and those making requests for additional staff. Mrs Foster confirmed that the Trust had focused on recruitment of band 5 nursing staff and emphasised the need to also maintain focus on recruitment initiatives for Care Support Workers, to avoid incurring a gap in the future.

10.7 Dr Tolcher referred to the statement in the report that a 'shortfall gaps in staffing did not reflected a risk to patient safety' and requested clarity on the statement. Mrs Foster confirmed that the statement reflected a *possible* risk, which was being appropriately mitigated. Incidents relating to staffing levels continued to be closely monitored.

11. Report from the Medical Director

The report had been circulated in advance of the meeting and was taken as read.

There were no further comments from members of the Board.

12. Report by the Director of Workforce and Organisational Development

The report had been circulated in advance of the meeting and was taken as read.

12.1 Following a detailed options appraisal for the role of Freedom to Speak Up Guardian considered by Director Team in September, Mr Marshall confirmed the recommendation to add the role to that of Dr Sylvia Wood, the Deputy Director of Governance. Dr Wood would be registered with the national Freedom to Speak Up office as the named contact for the Trust.

12.2 Mr Marshall provided an update on appraisal compliance and confirmed that there had been a successive increase in compliance rates during July and August and current levels of compliance stood at 73.55%. Mr Marshall also confirmed that the requirement to complete 90% of appraisals had been incorporated into the pay progression process for Line Managers. There had been strong evidence of teams undertaking team based appraisals.

12.3 Mr Marshall noted the Trust's sickness absence rate as 3.8% with the absence rate for the NHS as a whole as 4.443%. The Board also acknowledged the reduction in turnover.

12.4 The financial case to support the development of the Global Health Exchange Programme (GHEP) in India had been received and supported by the Director Team. The programme involved the potential to recruit 20 nurses from India and Mr Marshall noted that following negotiations, Health Education England (HEE) had agreed to fund a Band 6 facilitator to support the project.

12.5 Mr Marshall briefed the Board on the forthcoming visit from HEE to review the quality of training in General Surgery/Trauma and Orthopaedics/Urology/Obstetrics and Gynaecology/Acute Medical Specialties, and Foundation trainees placed in all specialties.

The Board noted the unfortunate timing in terms of planning with the visit planned to take place one day following the start date for trainees.

12.6 Following a request from Board members at the July meeting of the Board, Mr Marshall referred to the summary feedback from the Staff Friends and Family Test (SFFT), and noted an improvement in the number of staff choosing HDFT as a place to work. It was also noted that the number of staff recommending HDFT as a place to be treated had deteriorated, however, Mr Marshall referred to the intelligence from the free-text feedback and suggested that this had been due to a misinterpretation of the question. For example, patients may prefer other Trust's as they would be closer to home for their friends and family. In terms of next steps, the team would correlate the response from the SFFT and the Patient Friends and Family Test to identify common themes. It was acknowledge that the Trust continued to perform well above the national average, but would continue to strive for improvement.

12.7 Mr McLean noted the modest improvement relating to appraisal compliance, but expressed his disappointment at the speed of progress. Mr Marshall briefed the Board on the actions taken to improve performance and the drive for 90% compliance. Dr Tolcher referred to the decision to link compliance rates to pay progression for Line Managers and asked if consideration had been taken into account for those members of staff already at the top of their pay bands. Mr Marshall noted that a review of Agenda for Change terms of service would be undertaken to explore the possibility of incorporating a methodology to 'earn' the final point on a pay band on an annual basis.

12.8 Dr Tolcher referred to recent discussions regarding staff governor involvement in gaining intelligence on the value of staff appraisals. Mr Marshall confirmed that current intelligence suggests the barrier to completion of appraisals related to time and capacity issues. Terms of reference had been developed for staff governors to gain further intelligence in this regard.

12.9 Mr Ward referred to the adverse impact on staff of not holding regular appraisals in terms of expectations and objectives on a personal level and suggested that some of the Non-Executive Director cohort be involved in discussions in terms of learning from approaches in other sectors. Mr Marshall advised the Board that the current process resulted from an extensive staff consultation process via the Learning and Development Team. Mrs Dodson summarised by asking the Executive Team to consider further initiatives to raise appraisal compliance levels and submit a further update as part of the October Director of Workforce and Organisational Development report.

12.10 Mrs Webster referred to the response rate for the SFFT. Mr Marshall agreed that the response rate could be improved from the current 23%, and noted the national average as 13%.

12.11 Mr Thompson took an opportunity to commend the Workforce and Organisational Development Team for the continued reduction in sickness absence rates, particularly in relation to long term sickness absence. With regard to the Children's and County Wide Community Services directorate, Mr Thompson asked about the confidence levels within the directorate to reduce the sickness absence figures in line with the rest of the Trust. Mr Marshall advised that he was confident a reduction would occur but emphasised the need for consistent application of the policy and process.

ACTION:

- **Report on actions undertaken to support the increase required in appraisal compliance rates as part of the October Director of Workforce and Organisational Development report**

13. Oral Reports from Directorates

13.1 Children's and County Wide Community Services directorate

13.1.1 Dr Lyth introduced Mr Richard Chillery as the new Operational Director for Children's and County Wide Community Services directorate.

13.1.2 Dr Lyth briefed the Board on the implementation of the community bus and noted the opportunity to raise the profile of the nursing service and the 'growing healthy' campaign in different areas of County Durham.

13.1.3 With regard to the Wheelchair Service, Dr Lyth referred to the financial challenges previously discussed, and asked the Board to be mindful of the impact on members of staff within the service resulting from the adverse impact on patient care.

13.1.4 Dr Lyth referred to the large footprint for Children's Services and the likelihood of an increase in the number of Serious Case Reviews (SCRs) and Domestic Homicide Reviews (DHRs) as a result. SCRs and DHRs involve a multi-agency approach to reviewing cases and establishing lessons to be learnt. Ms Lorraine Fox, Head of Safeguarding had developed a mechanism for reporting such reviews and Mrs Foster suggested that a brief update on any reviews be included in the Chief Nurse Report, with detailed reports to be included in the private session of the Board.

13.1.5 Following the patient story, Dr Lyth referred to the Trust's successful bid for the 0-5 service, and the need for closer integrated working particularly between Health Visitors and the prevention teams.

13.1.6 Dr Lyth noted 97% performance with regard to the Newborn Blood Spot Test (Heel prick test).

13.1.7 With regard to the Patient Friends and Family Test, Dr Lyth noted that a new approach was under development for children. Mr McLean suggested learning from other Trusts and Dr Lyth confirmed that the team were trying to establish best practice in other areas. Dr Tolcher referred to a recent patient safety visit to Woodlands ward and referred to the possibility of sourcing an App which could be to engage younger patients.

13.2 Long Term and Unscheduled Care directorate

13.2.1 Mr Alldred took an opportunity to thank the Pathology Department for their effort to support colleagues in Leeds Teaching Hospitals NHS Trust, and noted the significant risks identified in terms of disaster recovery.

13.2.2 Mr Alldred also took an opportunity to thank Mr Harrison in terms of supporting the Long Term and Unscheduled Care directorate and noted that Mr Mike Forster, Operational Director was due to commence in post on 3 October.

13.2.3 In terms of risks, Mr Alldred referred to the headroom and capacity issues within the directorate which remained challenging, and expressed his thanks to the members of staff who continued to go the extra mile to maintain patient safety and high quality care.

13.3 Planned and Surgical Care directorate

13.3.1 Dr Johnson noted theatre staffing as the high risk area within the directorate and referred to a high level of disquiet in terms of staffing as a result of reliance on agency staff. Dr Johnson noted a 34% gap at Band 5 level, rising to 51% when taking into consideration long term sickness absence and maternity absence. It was also acknowledged that sickness absence rates remained above 8%.

13.3.2 Dr Johnson noted that recruitment of Operational Department Practitioners (ODPs) and Theatre Nurses was a national issue, as well as morale in theatres.

13.3.3 A report would be submitted to the Planned and Surgical Care Directorate Board on recruitment and retention. Dr Johnson requested further exploration of opportunities to recruit ODPs and Theatre Nurses as part of the GHEP. Mrs Foster and Mr Marshall agreed to support the directorate via the programme and international recruitment where possible.

13.3.4 Dr Johnson referred to the surgical middle grade tiers and the forthcoming deanery visit and confirmed that the Trust was not compliant with the requirement for on-site support for trainees when on-call overnight, and advised that work was underway with the Local Education and Training Boards (LETB), Clinical Leads and the workforce teams to explore alternative ways of managing surgical on-call.

13.3.5 Dr Tolcher referred to Dr Johnson's update which further highlighted the need to tactically move away from reliance on doctors in training.

ACTION:

- **To explore feasibility of recruitment opportunities for ODPs and Theatre Nurses via the Global Health Exchange Programme and international recruitment.**

14. Committee Chair Reports

14.1 Report from the Quality Committee meetings held 3 August and 7 September 2016

The reports had been circulated in advance of the meeting and were taken as read.

14.1.1 Mrs Webster noted that the committee received the GP Out of Hours report which provided additional assurance regarding GP auditing, appraisal and training activity. The report also provided examples of data reporting to demonstrate progress for accurately monitoring activity in relation to National Quality Requirements reporting. A further report would be received at the October meeting.

14.1.2 The Committee received further assurance with regard to the use of TACCORD (prompt to review and record thromboprophylaxis, antibiotics, cannula, catheter, oxygen, resuscitation status and dementia screening).

14.1.3 Following the independent review of the Trust's governance arrangements in line with the Regulator's Well Led Review Framework, Mrs Webster referred to the improved Patient Safety report which provided valuable insight for the committee and its members.

14.1.4 Mrs Webster referred to the proposal to report on the Trust's safety culture on a bi-annual basis. The report would triangulate benchmarking data to measure the Trusts patient safety culture.

14.2 Report from the Finance Committee meeting held 5 September 2016

The report had been circulated in advance of the meeting and was taken as read.

14.2.1 Mrs Taylor noted progress had been made with regard to outstanding debts and in the prompt invoicing of amounts due. Consideration would be given to the use of relationship managers to raise the issue of outstanding debts as part of their regular discussions.

14.2.2 Service line reporting information was provided for some specific areas. It was agreed that following the conclusion of the sustainability and transformation planning process, service line reporting would help the Trust focus on specific review areas.

14.3 Report from the Audit Committee meeting held 8 September 2016

The report had been circulated in advance of the meeting and was taken as read.

14.3.1 Mr Thompson noted that the committee continued to focus on the clearance on Internal Audit recommendations. Mrs Foster attended the meeting to provide assurance regarding recommendations relating to: IV cannula care; ward staffing and rostering; and discharge planning.

14.3.2 Mr Thompson referred to concerns raised by the committee regarding risks associated with the loss and security management implications of the new Children's Services contracts, and a request was made that these issues were re-assessed by the Corporate Risk Review Group.

14.3.3 Mr Thompson confirmed that the Audit Committee received and approved for onward submission to the Board, the Procurement Transformation Plan, the Treasure Management Policy, the Standing Financial Instructions and Standing Orders.

15. Council of Governor meeting 18 May 2016

The minutes of the Council of Governor meeting held 18 May had been previously circulated and were taken as read.

There were no further comments relating to the minutes of the meeting.

16. Matters relating to compliance with the Trust's Licence or other exceptional items to report.

16.1 To approve the annual statement of compliance for revalidation

16.1.1 The report outlined the responsibilities of the Trust's Responsible Officer which included a duty to be assured that doctors had sufficient knowledge of the English language necessary for the work to be performed in a safe and competent manner. The Board were asked to note that for the year 2015/16 the Trust had complied with all requirements for a Designated Body laid down by legislation and NHS England.

16.2 To approve the Emergency Preparedness Resilience and Response Core Standards Self-Assessment and Statement of Compliance

16.2.1 A self-assessment had been undertaken against the required areas of the NHS England Core Standards for Emergency Preparedness, Resilience and Response version 4.0. The Trust had been self-assessed as demonstrating 'Substantial' compliance level against the

core standards. Mr Harrison referred to areas of partial compliance, the detail of which was available in the Reading Room.

16.3 To approve the Procurement Transformation Plan

16.3.1 Following the requirement of Lord Carter's report the Board were provided with the local Procurement Transformation Plan (PTP) for the Trust. It was acknowledged that the plan had been considered by the Audit Committee at its meeting on 8 September for onward submission to the Board.

16.4 To approve the Treasury Management Policy

16.4.1 The Board were provided with the annual review of the Trust's Treasury Management Policy and it was acknowledged that the Policy had been considered by the Audit Committee at its meeting on 8 September for onward submission to the Board.

APPROVAL:

- **The Board of Directors approved the Annual Statement of Compliance for Revalidation and delegated authority to Dr Ros Tolcher, Chief Executive and Mrs Sandra Dodson, Chairman as signatories on behalf of the Trust.**
- **The Board of Directors approved the EPRR Statement of Compliance and delegated responsibility Mr Robert Harrison, Chief Operating Officer/Accountable Emergency Officer on behalf of the Trust.**
- **The Board of Directors approved the Procurement Transformation Plan.**
- **The Board of Directors approved the Treasury Management Policy.**

17. Any other relevant business not included on the agenda

There being no other business, Mrs Dodson declared the meeting closed.

17.1 Mrs Dodson briefed the Board on the Trust's decision to take part in The Insight Programme, aimed at improving the quality and diversity of NHS Boards. The programme involved arrangements for aspiring NHS Non-Executive Directors to be attached to NHS Trusts for a specified period of time.

In each Trust the candidates would 'buddy' with an existing Non-Executive Director and are mentored by the Chair. Mrs Dodson agreed to circulate a briefing for members of the Board.

18. Board Evaluation

Mrs Dodson referred to the powerful and impactful patient story.

Mr Alldred felt that the Board did not have an opportunity to recognise the high quality of care delivered by Trust. Dr Tolcher reflected on the July Board strategy day and the commitment of the Board to move to a more strategic approach, and stated that delivery of high quality care was implicit in this.

Mr McLean agreed that the Board's ability to focus on strategic discussions was crucial and noted the importance of discussing the risks associated with theatre staffing and middle grades, and the associated impact on quality of care, income and staff retention.

The value of directorate colleagues in attendance and contributing to Board discussions was highlighted in terms of visibility for Board members on hot spots across the organisation.

Mr Harrison suggested that the recent review of the directorate structures had helped the Board in terms of covering the Trust's portfolio more effectively.

19. Confidential Motion

The Chairman moved 'that members of the public and representatives of the press be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'.

The Board agreed the motion unanimously.

The meeting closed at 12.50pm

DRAFT

HDFT Board of Directors Actions Schedule as at October 2016
Completed Actions

This document logs actions completed since the previous Board of Director meeting. Completed items will remain on the schedule for three months and then be removed.

Item Description	Director/ Manager Responsible	Date of completion/ progress update	Confirm action Complete
Verbal update to be provided as part of the Quality Committee Chair's report on performance relating to completion of complaint action plans (Jun 16)	Mrs L Webster, Non-Executive Director/ Quality Committee Chair	September 2016	Complete
Further detail on metrics relating to health visiting for new born visits to be provided in the IBR (Jun 16)	Dr N Lyth, Clinical Director	September 2016	Complete – paper included for July meeting
An update on the NHS Improvement consultation and proposals for a Single Oversight Framework to be provided (Jul 16)	Dr R Tolcher, Chief Executive	September 2016	Complete – included in CEO Report. Consultation response uploaded to reading room
Provide confirmation of the Trust's current compliance with legionella water testing (July 16)	Mr R Harrison, Chief Operating Officer	September 2016	Included on Board Assurance Framework
Clarity to be sought to ensure that the current compliance rates for Information Governance Mandatory training support the requirements of the July Information Toolkit submission (July 16)	Mr R Harrison, Chief Operating Officer	September 2016	Complete – response circulated to Board members via e-mail 8/8/16
The suggestion to nominate a Director lead for Nursing for WYAAT to be taken forward for discussion at the next WYAAT CEO meeting (July 16)	Dr R Tolcher, Chief Executive	August/ September 2016	Complete
An update on the review of the Staff Friends and Family Test narrative outcome for Q1 to be provided to the Board (Jul 16)	Mr P Marshall, Director of Workforce and Organisational Development	September 2016	Complete – included within DWOD report
Provide assurance to the Board in relation to service activity and recovery plans (Jul 16)	Mr R Harrison, Chief Operating Officer	September 2016	Complete – within COO report
Assurance to be sought from the contracts team that no penalties associated with the contract could be implemented due to the absence of a threshold target for new birth visits by Health Visiting team within 14 days of birth (Jul 16)	Mr J Coulter, Deputy Chief Executive/ Finance Director	September 2016	Complete

Item Description	Director/ Manager Responsible	Date of completion/ progress update	Confirm action Complete
E-rostering implementation update to be included in the Chief Nurse report (Jul 16)	Mrs J Foster, Chief Nurse	September 2016	Complete – verbal update provided as part of CN report to September meeting
Progress with regard to the appointment of Consultant Elderly Care post as part of the oral directorate report (May and Jun 16)	Dr K Johnson, Clinical Director	September 2016	Complete – provided under Directorate reports at September meeting
Proposal for the appointment of the Trust's Freedom to Speak Up Guardian to be submitted to the Board of Directors (Jul 16)	Mr P Marshall, Director of Workforce and OD	October 2016	Complete – reported as part of DWOD report at the September meeting
The Board of Directors approved the revisions to the wording of the Trust's vision, mission and objectives subject to the amendment to change 'endeavour' to 'strive' (Sep 16)	Dr R Tolcher, Chief Executive	October 2016	Complete
Explore feasibility of recruitment opportunities for ODPs and Theatre Nurses via the Global Health Exchange Programme and international recruitment (Sep 16)	Mr P Marshall, Director of Workforce and Organisational Development	October 2016	Complete
Undertake a review of the Strategic Key Performance Indicators and submit a proposal to the October meeting of the Board for approval, giving consideration to input from the Shadow Board (Jul 16)	Mr J Coulter, Deputy Chief Executive/Finance Director	October 2016	Complete – agenda item
Include a 6-month financial forecast within the October Finance Director report (Sept 16)	Mr J Coulter, Deputy Chief Executive/Finance Director	October 2016	Complete – include in Finance Directors Report
Write to Gill Morgan, Chair of NHS Providers to outline concerns regarding the impact of STPs on executive capacity (6.29)	Mrs S Dodson, Chairman	October 2016	Complete
IBR – narrative associated with GP out of hours to be improved to reflect the level of activity undertaken for future reports (Sept 16)	Mr A Alldred, Clinical Director	October 2016	Complete – included in IBR

HDFT Board of Directors Actions Schedule – Outstanding Actions as at October 2016

This document logs items for action from Board of Directors meetings which remain outstanding. Board members will be asked to confirm completion of actions or give a progress update at the following Board meeting when they do not appear on a future agenda.

Ref	Meeting Date	Item Description	Director/Manager Responsible	Completion date	Detail of progress
1	September 2016	Report on actions undertaken to support the increase required in appraisal compliance rates as part of the October DWOD report.	Mr P Marshall, Director of Workforce and OD	October 2016	Included in the CEO board report
2	June 2016	Update on the action plan following the Alan Wood Report into Local Safeguarding Boards (12.6)	Mrs J Foster, Chief Nurse	November 2016	Verbal update to be provided under matters arising
3	June 2016 July 2016	Additional information to be included in the IBR relating to readmissions of older people (Jun 8.3) / update on reducing readmissions in older people to be submitted to the September Board meeting (8.9)	Mr A Allred, Clinical Director	November 2016	Awaiting outcome of the case note review
4	March 2016	Submission of a Research and Development Strategy for Board comment	Dr A Layton - Associate Director for Research	November 2016	On track
5	January 2016	Review and revise questions in annual Audit Committee survey (14.1.3)	Mr C Thompson, Non-Executive Director	November 2016	On track
6	May 2016	Further update on progress of the Care of Frail Older People Strategy and confirm an NED Lead (11.2.3)	Mr A Allred, Clinical Director	November 2016	On track
7	September 2016	Inclusion of KPIs on Children's Services and Community Services to be included in the IBR following a review of the new dashboard for the Directorate (4.1)	Dr N Lyth, Clinical Director	November 2016	On track
8	September 2016	Update on management of risks associated with the wheelchair service to be provided at a future meeting of the Board (8.5)	Mr J Coulter, Deputy Chief Executive/ Finance Director	November 2016	To be included in the Business Development report for Board in private session
9	September 2016	Revisit the Board Assurance Framework to ensure adequate reflection of executive team capacity to delivery wider strategic initiatives (6.9)	Dr Ros Tolcher, Chief Executive	November 2016	Complete – to be discussed in full in Board in private

10	June 2016	Update on the programme of work to reduce hospital admissions (9.3)	Mr A Alldred, Clinical Director	January 2017	
11	January 2016	Update Board on progress with EDS2 action plan (11.10)	Mrs J Foster – Chief Nurse	January 2017	
12	September 2016	Provide an update on progress with regard to actions associated with Corporate Risk Register CR8: risk of ophthalmology patients being lost to follow up (6.13)	Dr K Johnson, Clinical Director	January 2017	
13	March 2016	Additional information on learning from cases of C. Diff and associated action planning during 2015/16 to be included in the annual report (6.3)	Mrs J Foster, Chief Nurse	February 2017	

Report to the Trust Board of Directors: 26 October 2016	Paper No: 5.0
Title	Strategic KPIs Report
Sponsoring Director	Dr R Tolcher, Chief Executive
Author(s)	Ms Rachel McDonald, Head of Performance & Analysis Mrs Samantha McLachlan, Assistant Planning Manager
Report Purpose	To update the Board in relation to Strategic KPIs.
Key Issues for Board Focus:	
<p>The Strategic KPIs contained within this report have been updated and amended in line with recent feedback received from the Board of Directors and the Executive Team.</p> <p>Key issues to note:</p> <ul style="list-style-type: none"> • Positive external validation of the Trust's performance; • A pause in discussions across the local system in respect of alternative contract and payment mechanisms; • Benchmarking our corporate costs against Carter targets for future years is positive; • More action to undertake over the next year in terms of catchment population and out of Harrogate activity, as part of local and WY STP discussions; • Indications of positive trends in terms of avoidable admissions and non-elective bed days. 	
Related Trust Objectives	
To deliver high quality care	Yes – the report tracks progress against the agreed strategic KPIs for monitoring delivery of high quality care.
To work with partners to deliver integrated care	Yes – the report tracks progress against the agreed strategic KPIs for monitoring working with partners to deliver integrated care.
To ensure clinical and financial sustainability	Yes – the report provides the Board with assurance on progress of work across the region to ensure clinical and financial sustainability.
Risk and Assurance	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF# 1: risk of a lack of medical, nursing and clinical staff; BAF# 2: risk of a high level of frailty in local population; BAF# 9: risk of failure to deliver the operational plan; and BAF# 12: external funding constraints.
Legal/regulatory implications	The report does not highlight any legal/regulatory implications for the period.
Action Required by the Board of Directors	
The Board of Directors are asked to receive and note the content of the report.	

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Delivering High Quality Care - September 2016

Area	Indicator	Description	Trend chart	Interpretation
Patient Safety	Senior patient reviews within 14 hours	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.	<p>2a) % of patients admitted as an emergency who receive a thorough clinical assessment by a suitable consultant (seven days a week) within 14 hours of arrival at hospital</p>	<p>NHS England have mandated that reviews take place on a 6 monthly basis and the chart opposite shows the results of the March 2016 review. HDFT undertook a prospective case note review of 40 emergency admissions per day. The chart opposite was compiled by Bradford Teaching Hospitals Trust and shows a comparison of Yorkshire Trusts on their % of patients admitted as an emergency who received a thorough clinical assessment by a suitable consultant within 14 hours of arrival.</p>
	Proportion of high/low risks. Reporting culture. Total no incidents, % that are high	<p>The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture.</p>		<p>The latest published national data shows that Acute Trusts reported an average ratio of 34 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's local reporting ratio for the same period was 18 which places the Trust in the bottom 25% nationally. There was an increase in moderate harm incidents reported by HDFT during this period - reasons for this are known and include the fact that duty of candour was introduced in this period and there was a change in the way staff assessed severity.</p>
Patient Experience	Reduction in number of complaints per 1000 contacts referencing communication	<p>The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.</p>		<p>18 complaints were received in September compared to 25 last month, with none classified as amber or red. This is in line with the 2015/16 average per month of 18.</p>

Delivering High Quality Care - September 2016

Area	Indicator	Description	Trend chart	Interpretation																																																
Patient Experience	<p>Friends & Family Test (FFT) - Staff - % recommend as a place to receive care</p>	<p>The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in.</p> <p>The chart shows the percentage of staff that would recommend the Trust as a place to receive care. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally which would typically mean that 88% of staff would recommend the Trust as a place to work.</p>	<table border="1"> <caption>Staff Friends and Family Test Data</caption> <thead> <tr> <th>Quarter</th> <th>% recommended - care - HDFT</th> <th>% recommended - care - national</th> </tr> </thead> <tbody> <tr><td>Q1 14/15</td><td>85%</td><td>78%</td></tr> <tr><td>Q2 14/15</td><td>88%</td><td>78%</td></tr> <tr><td>Q3 14/15</td><td>88%</td><td>78%</td></tr> <tr><td>Q4 14/15</td><td>88%</td><td>78%</td></tr> <tr><td>Q1 15/16</td><td>88%</td><td>78%</td></tr> <tr><td>Q2 15/16</td><td>92%</td><td>78%</td></tr> <tr><td>Q3 15/16</td><td>88%</td><td>78%</td></tr> <tr><td>Q4 15/16</td><td>88%</td><td>78%</td></tr> <tr><td>Q1 16/17</td><td>88%</td><td>78%</td></tr> <tr><td>Q2 16/17</td><td>92%</td><td>78%</td></tr> </tbody> </table>	Quarter	% recommended - care - HDFT	% recommended - care - national	Q1 14/15	85%	78%	Q2 14/15	88%	78%	Q3 14/15	88%	78%	Q4 14/15	88%	78%	Q1 15/16	88%	78%	Q2 15/16	92%	78%	Q3 15/16	88%	78%	Q4 15/16	88%	78%	Q1 16/17	88%	78%	Q2 16/17	92%	78%	<p>In Q2, 87.3% of HDFT staff surveyed would recommend HDFT as a place to receive care. This is an increase on Q1 and above the most recently published national average of 80%.</p> <p>The Staff, Friends and Family Test is now surveying the whole Trust rather than by Directorate. This will allow us to benchmark our response rate. During 2015/16, the whole Trust was only surveyed during Q3.</p>															
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<p>Friends & Family Test (FFT) - Patients</p>	<p>The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.</p>	<table border="1"> <caption>Patient Friends and Family Test Data</caption> <thead> <tr> <th>Month</th> <th>% recommend</th> <th>HDFT mean</th> </tr> </thead> <tbody> <tr><td>Apr-14</td><td>92%</td><td>94.3%</td></tr> <tr><td>Jul-14</td><td>88%</td><td>94.3%</td></tr> <tr><td>Oct-14</td><td>95%</td><td>94.3%</td></tr> <tr><td>Jan-15</td><td>95%</td><td>94.3%</td></tr> <tr><td>Apr-15</td><td>92%</td><td>94.3%</td></tr> <tr><td>Jul-15</td><td>95%</td><td>94.3%</td></tr> <tr><td>Oct-15</td><td>95%</td><td>94.3%</td></tr> <tr><td>Jan-16</td><td>88%</td><td>94.3%</td></tr> <tr><td>Apr-16</td><td>95%</td><td>94.3%</td></tr> <tr><td>Jul-16</td><td>95%</td><td>94.3%</td></tr> </tbody> </table>	Month	% recommend	HDFT mean	Apr-14	92%	94.3%	Jul-14	88%	94.3%	Oct-14	95%	94.3%	Jan-15	95%	94.3%	Apr-15	92%	94.3%	Jul-15	95%	94.3%	Oct-15	95%	94.3%	Jan-16	88%	94.3%	Apr-16	95%	94.3%	Jul-16	95%	94.3%	<p>94.3% of patients surveyed in September would recommend our services, a slight reduction on last month but remaining above the latest published national average.</p> <p>The technical problems with the automated phone call service were fixed in early August and phone calls reinstated to all services that were previously using them.</p>																
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Patient outcomes	<p>Reducing readmissions in older people</p>	<p>The chart shows the proportion of older people aged 65+ who were still at home 91 days after discharge from hospital into rehabilitation or reablement services. A high figure is good.</p> <p><i>This indicator is in development.</i></p>	<table border="1"> <caption>Proportion of older people still at home 91 days after discharge</caption> <thead> <tr> <th>Month</th> <th>% not readmitted</th> <th>HDFT mean</th> </tr> </thead> <tbody> <tr><td>Apr-15</td><td>72%</td><td>75%</td></tr> <tr><td>May-15</td><td>72%</td><td>75%</td></tr> <tr><td>Jun-15</td><td>72%</td><td>75%</td></tr> <tr><td>Jul-15</td><td>72%</td><td>75%</td></tr> <tr><td>Aug-15</td><td>78%</td><td>75%</td></tr> <tr><td>Sep-15</td><td>72%</td><td>75%</td></tr> <tr><td>Oct-15</td><td>72%</td><td>75%</td></tr> <tr><td>Nov-15</td><td>78%</td><td>75%</td></tr> <tr><td>Dec-15</td><td>78%</td><td>75%</td></tr> <tr><td>Jan-16</td><td>72%</td><td>75%</td></tr> <tr><td>Feb-16</td><td>72%</td><td>75%</td></tr> <tr><td>Mar-16</td><td>72%</td><td>75%</td></tr> <tr><td>Apr-16</td><td>72%</td><td>75%</td></tr> <tr><td>May-16</td><td>78%</td><td>75%</td></tr> <tr><td>Jun-16</td><td>75%</td><td>75%</td></tr> </tbody> </table>	Month	% not readmitted	HDFT mean	Apr-15	72%	75%	May-15	72%	75%	Jun-15	72%	75%	Jul-15	72%	75%	Aug-15	78%	75%	Sep-15	72%	75%	Oct-15	72%	75%	Nov-15	78%	75%	Dec-15	78%	75%	Jan-16	72%	75%	Feb-16	72%	75%	Mar-16	72%	75%	Apr-16	72%	75%	May-16	78%	75%	Jun-16	75%	75%	<p>For patients discharged in June, 75% were still in their own home at the end of September, a decrease on the previous month.</p> <p>Following a deterioration in performance on this metric earlier this year, a case note audit of a sample of patients is being carried out to understand any themes and actions required and the results will be reported by Long Term and Unscheduled Care Directorate in the Autumn.</p>
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<p>Proportion of Best Practice Tariff achieved</p>	<p>The chart compares each key area of Best Practice Tariffs achieved/monitored from 2015/16 to 2016/17.</p>	<table border="1"> <caption>Best Practice Tariff Achievement</caption> <thead> <tr> <th>Area</th> <th>2015/16</th> <th>2016/17</th> </tr> </thead> <tbody> <tr><td>Daycase</td><td>65%</td><td>65%</td></tr> <tr><td>Ambulatory care</td><td>45%</td><td>45%</td></tr> <tr><td>Fragility Hip</td><td>55%</td><td>55%</td></tr> <tr><td>Stroke - part 1</td><td>75%</td><td>90%</td></tr> <tr><td>Stroke - part 2</td><td>85%</td><td>85%</td></tr> <tr><td>Outpatient incentivised</td><td>95%</td><td>95%</td></tr> </tbody> </table>	Area	2015/16	2016/17	Daycase	65%	65%	Ambulatory care	45%	45%	Fragility Hip	55%	55%	Stroke - part 1	75%	90%	Stroke - part 2	85%	85%	Outpatient incentivised	95%	95%	<p>The achievement of Best Practice Tariff has increased in 2016/17 for ambulatory care, fragility hip and stroke but has decreased for daycase and outpatient incentivised procedures.</p>																												
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Working with partners to deliver integrated care - September 2016

Indicator	Description	Trend chart	Interpretation
<p>Alliance contract in place for New Care Models</p>	<p>The narrative describes progress in relation to the development of an alternative contractual and payment mechanism for an extended scope of services across the Harrogate area</p>	<p>A working group has been established to explore alternative contracting and payment options. The scope of services to potentially be included in such an arrangement is still to be agreed, but would include adult community services and medical non-elective services. Legal support for the Vanguard has been procured to help develop contractual options. Following recent discussion at HHTB, it has been agreed to pause any development of this type of approach whilst contract negotiations and 2 year plans are worked on.</p>	
<p>Non-elective bed days</p>	<p>The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. A lower figure is preferable.</p>		<p>Non-elective bed days for patients aged 18+ have been lower over the last few months and are in line with the 2016/17 trajectory. The decrease may be partly due to seasonality, although the reduction appears to be more marked than in the previous year.</p> <p>The 2016/17 trajectory is based on allowing for demographic growth and reducing by the non-elective reductions identified in the Value Proposition. For next month, an additional trajectory will be calculated taking into account the impact of targetted reductions in length of stay through the transformation programmes.</p>
<p>Avoidable admissions</p>	<p>The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.</p>		<p>There were 182 avoidable admissions in August, a decrease on last month and below the HDFT average. There is some seasonality in this metric so a reduction during the summer months is expected. However this is lower than the level in the same period last year.</p> <p>An extra line has been added to the chart to show the number of avoidable admissions excluding CAT (Clinical Assessment Team) attendances and admissions aged 0-17 years. This allows us to isolate and track the adult emergency admissions that may be avoided by the New Care Model.</p>
<p>Delivery of IT strategy in line with agreed milestones</p>	<p>This narrative describes the progress in relation to the delivery of the IT strategy including WebV.</p>	<p>All partner organisations in the local health community have developed a Local Digital Roadmap (LDR) reflecting the ambition for information to be shared, accessed and added to by all partner organisations. This has been submitted to NHS England and initial feedback has been received and is positive.</p> <p>Partners involved in the Vanguard NCM IM&T work-stream were involved in the development and will continue to oversee further development and updates.</p> <p>The LDR reflects WebV as the Trust's integrated EPR (Electronic Patient Record) solution with the proof of concept work now underway and progressing well. Hardware and software have been installed and three initial projects are being taken forward covering: Clinical Noting; Electronic Patient Check-in; and a Clinical Portal.</p>	

Working with partners to deliver integrated care - September 2016

Indicator	Description	Trend chart	Interpretation
Patient satisfaction of new model of care	This narrative describes patient feedback in relation to the new models of care.		Patient feedback is being collated via the FFT but does not specify the team. We are in the process of rolling out new forms which are team specific to isolate feedback from Knaresborough, Boroughbridge and Green Hammerton specifically.

Clinical and Financial sustainability - September 2016

Indicator	Description	Trend chart	Interpretation																														
<p>Sufficient catchment population for key specialites of maternity, paediatrics and emergency surgery</p>	<p>This narrative describes progress in relation to the development of catchment areas for the key specialities of maternity, paediatrics and emergency surgery. The chart shows populations served by HDFT services in 2013 and in 2016.</p>	<p>Populations served by HDFT services</p> <table border="1"> <caption>Populations served by HDFT services (Estimated values)</caption> <thead> <tr> <th>Service</th> <th>2013</th> <th>2016</th> </tr> </thead> <tbody> <tr> <td>GP OOH</td> <td>~600,000</td> <td>~300,000</td> </tr> <tr> <td>Elective orthopaedics</td> <td>~600,000</td> <td>~600,000</td> </tr> <tr> <td>0-19 Children's Services</td> <td>~600,000</td> <td>~1,300,000</td> </tr> <tr> <td>Harrogate ED</td> <td>~300,000</td> <td>~350,000</td> </tr> <tr> <td>Births</td> <td>~300,000</td> <td>~300,000</td> </tr> <tr> <td>Emergency adms - surgical</td> <td>~200,000</td> <td>~200,000</td> </tr> <tr> <td>Emergency adms - medical</td> <td>~200,000</td> <td>~200,000</td> </tr> <tr> <td>Emergency adms - stroke</td> <td>~200,000</td> <td>~200,000</td> </tr> <tr> <td>District Nursing</td> <td>~200,000</td> <td>~200,000</td> </tr> </tbody> </table>	Service	2013	2016	GP OOH	~600,000	~300,000	Elective orthopaedics	~600,000	~600,000	0-19 Children's Services	~600,000	~1,300,000	Harrogate ED	~300,000	~350,000	Births	~300,000	~300,000	Emergency adms - surgical	~200,000	~200,000	Emergency adms - medical	~200,000	~200,000	Emergency adms - stroke	~200,000	~200,000	District Nursing	~200,000	~200,000	<p>Work has progressed to develop catchment areas for Maternity, Paediatrics and Emergency Surgery, with new developments in community midwifery outreach into Leeds, development of Endoscopy services in Wharfedale and Surgical Outpatients in Yeadon, changes in provision of Paediatrics and Maternity to the north of Harrogate and development of Paediatric outpatient services into Leeds. There has been increases in population bases in 0-19 services (127% from April 16), the Emergency Department (10%), Maternity (10%) and T&O (7%). Most other services have seen little change, with the exception of GPOOH where there has been a reduction of 50% due to the transfer of contract of the York GPOOH service.</p>
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<p>Increased share of HaRD CCG, Leeds North CCG and Leeds West CCG referrals</p>	<p>The chart shows the proportion of first outpatient attendances from each locality that are seen at HDFT. The data is sourced from the HED (Healthcare Evaluation Data) benchmarking system and only includes specialties for which HDFT run services.</p>	<table border="1"> <caption>Proportion of first outpatient attendances (Estimated values)</caption> <thead> <tr> <th>Locality</th> <th>2015/16</th> <th>2016/17 (Jul YTD)</th> </tr> </thead> <tbody> <tr> <td>LEEDS NORTH CCG</td> <td>~18%</td> <td>~18%</td> </tr> <tr> <td>LEEDS WEST CCG</td> <td>~2%</td> <td>~2%</td> </tr> <tr> <td>HARD CCG</td> <td>~86%</td> <td>~86%</td> </tr> </tbody> </table>	Locality	2015/16	2016/17 (Jul YTD)	LEEDS NORTH CCG	~18%	~18%	LEEDS WEST CCG	~2%	~2%	HARD CCG	~86%	~86%	<p>HDFT's market share in 2016/17 to date was 86% in HARD CCG, 18% in Leeds North CCG and 2% in Leeds West CCG, no significant change on the previous year.</p>																		
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<p>Surplus per occupied bed days</p>	<p>This indicator is in development</p>	<p>(This cell is currently blank in the report)</p>	<p>(This cell is currently blank in the report)</p>																														
<p>Income</p>	<p>The chart opposite shows the income achievement to date, excluding S&T funding.</p>	<p>Income (£m)</p> <table border="1"> <caption>Income (£m) (Estimated values)</caption> <thead> <tr> <th>Year</th> <th>Actual Income YTD</th> <th>Target Income YTD</th> <th>Planned Income (full yr)</th> </tr> </thead> <tbody> <tr> <td>2016/17</td> <td>~100</td> <td>~100</td> <td>~220</td> </tr> <tr> <td>2017/18</td> <td>-</td> <td>-</td> <td>~220</td> </tr> <tr> <td>2018/19</td> <td>-</td> <td>-</td> <td>~225</td> </tr> <tr> <td>2019/20</td> <td>-</td> <td>-</td> <td>~230</td> </tr> <tr> <td>2020/21</td> <td>-</td> <td>-</td> <td>~235</td> </tr> </tbody> </table>	Year	Actual Income YTD	Target Income YTD	Planned Income (full yr)	2016/17	~100	~100	~220	2017/18	-	-	~220	2018/19	-	-	~225	2019/20	-	-	~230	2020/21	-	-	~235	<p>Income plans are in line with Business Development Strategy, although we are currently behind plan.</p>						
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Clinical and Financial sustainability - September 2016

Indicator	Description	Trend chart	Interpretation
<p>I&E Surplus</p>	<p>This chart shows the I&E Surplus achievement to date, excluding S&T funding.</p>		<p>As at Q2 2016/17, our surplus (excluding S&T funding) is on plan. Future surpluses are in line with our Control Total and are reflected in our local and West Yorkshire STP plans.</p>
<p>Carter management costs</p>	<p>This indicator highlights the Hospital Management Overheads using 2016/17 data.</p>		<p>This chart shows that the Trust has operated its management costs below both the national average of 8% (Comparator) and next year's target of 7%. The data is up to and including September 2016.</p>
<p>Private income</p>	<p>This indicator is in development</p>		
<p>R&D income</p>	<p>Aspects of research studies are paid for by the study sponsor or funder.</p>		<p>As set out in the Research & Development strategy, the Trust intends to maintain its current income from commercial research activity and NIHR income to support research staff to 2019. Each study is unique. Last year the Trust invoiced for a total of £223k.</p>

External Monitoring - September 2016

Indicator	Description	Trend chart	Interpretation																				
<p>NHS Improvement Financial Risk Rating</p>	<p>The NHS Improvement Financial Sustainability Risk Rating is made up of two components, liquidity and capital service cover. An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns).</p>	<table border="1"> <thead> <tr> <th rowspan="2">Risk Rating</th> <th colspan="2">Year to Sep</th> </tr> <tr> <th>Plan</th> <th>Actual</th> </tr> </thead> <tbody> <tr> <td>Capital Service Capacity rating</td> <td>4</td> <td>4</td> </tr> <tr> <td>Liquidity rating</td> <td>4</td> <td>4</td> </tr> <tr> <td>I&E Margin rating</td> <td>4</td> <td>4</td> </tr> <tr> <td>I&E Margin Variance rating</td> <td>3</td> <td>4</td> </tr> <tr> <td>Financial Sustainability Risk Rating before overrides</td> <td>4</td> <td>4</td> </tr> </tbody> </table>	Risk Rating	Year to Sep		Plan	Actual	Capital Service Capacity rating	4	4	Liquidity rating	4	4	I&E Margin rating	4	4	I&E Margin Variance rating	3	4	Financial Sustainability Risk Rating before overrides	4	4	<p>The Trust will report a risk rating of 4 for the year to September. This is in line with the Trust plan. This indicator will change with effect from 1/10/16 in line with NHS Improvement Single Oversight Framework.</p>
Risk Rating	Year to Sep																						
	Plan	Actual																					
Capital Service Capacity rating	4	4																					
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I&E Margin rating	4	4																					
I&E Margin Variance rating	3	4																					
Financial Sustainability Risk Rating before overrides	4	4																					
<p>CQC Inspection Rating</p>	<p>CQC monitor, inspect and regulate health and social care services to make sure they meet fundamental standards of quality and safety and publish their findings. HDFT was last inspected by CQC in February 2016.</p>	<p>Ratings</p> <p>Overall rating for this trust Good ●</p> <table border="1"> <tbody> <tr> <td>Are services at this trust safe?</td> <td>Requires improvement ●</td> </tr> <tr> <td>Are services at this trust effective?</td> <td>Good ●</td> </tr> <tr> <td>Are services at this trust caring?</td> <td>Outstanding ☆</td> </tr> <tr> <td>Are services at this trust responsive?</td> <td>Good ●</td> </tr> <tr> <td>Are services at this trust well-led?</td> <td>Good ●</td> </tr> </tbody> </table>	Are services at this trust safe?	Requires improvement ●	Are services at this trust effective?	Good ●	Are services at this trust caring?	Outstanding ☆	Are services at this trust responsive?	Good ●	Are services at this trust well-led?	Good ●	<p>Overall, HDFT was given a "good" rating in the inspection report published by CQC in July 2016. A further breakdown of the rating is provided in the table to the left. Following publication of the report, the Trust agreed an action plan with CQC and HARD CCG to address the small number of issues identified during the inspection. Actions are now being progressed with a view to an early re-inspection.</p>										
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Are services at this trust well-led?	Good ●																						
<p>Patient Survey</p>	<p>The national adult inpatient survey for 2015 was published in May 2016. 621 patients treated at HDFT responded in the survey this year - a local response rate of 52%, compared to 56% last year. The national response rate was 45%.</p>		<p>In 18 out of the 65 questions, HDFT scored significantly better than average, about the same as average for 46 questions and significantly below average for 1 question - 'Not asked to give views on quality of care' where 73% of HDFT patients agreed with this question compared to 69% national average.</p> <p>In terms of HDFT's overall ranking compared to other trusts, HDFT was ranked 14th out of 136 Trusts that answered all the questions in the survey. This compares to 10th out of 140 Trusts last year.</p>																				
	<p>The results of the national cancer patient survey 2015 were recently published. 455 HDFT patients were asked to take part in the survey and 317 (74%) completed and returned it. This is a greater response rate than the national average of 66%.</p>		<p>When taking an average of all the Trusts adjusted scores, HDFT came 3rd out of the 146 Trusts which took part in the survey achieving an average score of 80%. However, of the trusts which responded to all the questions, HDFT came top out of 131.</p> <p>Asked to rate their care on a scale of zero (very poor) to 10 (very good), HDFT respondents gave an average rating of 8.9.</p>																				

External Monitoring - September 2016

Indicator	Description	Trend chart	Interpretation								
<p>Staff Survey (Top 10%)</p>	<p>The results shown are taken from the 2015 Staff Engagement Score.</p>	<p style="text-align: center;">OVERALL STAFF</p> <p><i>(the higher the score the better)</i></p> <p style="text-align: center;">Scale summary score</p> <table border="1"> <caption>Staff Engagement Scores</caption> <thead> <tr> <th>Category</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Trust score 2015</td> <td>3.92</td> </tr> <tr> <td>Trust score 2014</td> <td>3.83</td> </tr> <tr> <td>National 2015 average for combined acute and community trusts</td> <td>3.79</td> </tr> </tbody> </table>	Category	Score	Trust score 2015	3.92	Trust score 2014	3.83	National 2015 average for combined acute and community trusts	3.79	<p>The figure shows how HDFT compares with other combined acute and community Trusts on an overall indicator of staff engagement. Possible scores ranged from 1 to 5, (1 indicating poorly engaged staff and 5 indicating highly engaged staff). The Trust's score of 3.92 was above average when compared with Trusts of a similar type, however, there wasn't a top 10% category within the survey.</p> <p>This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7, which relate to: staff members' perceived ability to contribute to improvements at work (KF7); their willingness to recommend the trust as a place to work or receive treatment (KF1); and the extent to which they feel motivated and engaged with their work (KF4).</p>
Category	Score										
Trust score 2015	3.92										
Trust score 2014	3.83										
National 2015 average for combined acute and community trusts	3.79										

Report to the Trust Board of Directors: 26 October 2016	Paper No: 6.0
Title	Report from Chief Executive
Sponsoring Director	Dr Ros Tolcher, Chief Executive
Author(s)	Dr Ros Tolcher, Chief Executive
Report Purpose	To update the Board of Directors on significant strategic, operational and performance matters
Key Issues for Board Focus:	
<ul style="list-style-type: none"> Progress has been made in developing the West Yorkshire Sustainability and Transformation Plan The development of the Trust's Operation plan for 2017/18 and 2018/19 is underway and will be aligned to the content of the West Yorkshire Sustainability and Transformation Plan Continued progress has been made to improve staff appraisal rates Further work has taken place to ensure that the Trust has controls and actions in place to reduce agency spend The Trust has received notification of its control total for 2017/18 and 2018/19. Significant progress has been made to improve financial performance via recovery plans implemented at directorate level The West Yorkshire Association of Acute Trusts continues to work collaboratively to develop a Committee in Common to improve partnership working A new risk has been added to the Board Assurance Framework to reflect the impact of Sustainability and Transformation planning on senior leadership capacity 	
Related Trust Objectives:	
1. To deliver high quality care	Yes – the report reflects a sustained organisational focus on providing high quality care and ensuring robust controls and assurances on care quality.
2. To work with partners to deliver integrated care	Yes – the report provides updates on the work of the HHTB and West Yorkshire reflect partnership working in Harrogate and West Yorkshire areas.
3. To ensure clinical and financial sustainability	Yes – the report notes from the SMT meeting demonstrate a particular focus on financial performance
Risk and Assurance	Strategic and operational risks are noted in section 6. Risks associated with this report are reflected in the Board Assurance Framework: BAF 14: risk to deliver of integrated models of care; BAF 4: lack of interoperable systems across New Care Models; BAF 15: misalignment of partner strategic plans; and BAF 9; failure to deliver the operational plan.
Legal implications/Regulatory Requirements	There are no legal/regulatory implications highlighted within the report.
Action Required by the Board of Directors	
<ul style="list-style-type: none"> The Board is requested to note the strategic and operational updates The Board is asked to note progress on risks recorded in the BAF and Corporate Risk Register and confirm that progress reflects the current risk appetite. The Board is asked to agree the additional risk (BAF 6) relating to the impact of sustainability and transformation planning on senior leadership capacity 	

1.0 MATTERS RELATING TO QUALITY AND PATIENT EXPERIENCE

1.1 2017/18 – 2018/19 Operating Plan development

NHS Foundation Trusts and Trusts are required to submit draft 2-year Operating Plans by the end of November and final 2-year plans by 23 December. NHS Improvement has also set an expectation that contracts for the 2-year period will have been agreed by the end of December. The Trust is in close dialogue with commissioners to develop plans and has had early discussions with NHS Improvement.

Further information of the development of the Trust's Operational Plan can be found in the Operational Planning Report.

1.2 Staff Appraisal Compliance

An important agreement has been reached with our trade union colleagues through negotiation via the Trust's Employment Policy Advisory Group. This has resulted in the amendment of the existing Pay Progression Policy which, with immediate effect, now makes it mandatory for line managers to have achieved 90% appraisal compliance for members of their team, in order for the manager concerned to qualify for their own annual pay progression. This is a significant development and clearly links appraisal to pay progression for our workforce. I am grateful to our trade union colleagues for their support in agreeing to this policy amendment.

Meetings have now been arranged between the Director of Workforce and Organisational Development and the Clinical Directors, Operational Directors and some General Managers from each Directorate. The purpose of these meetings will be to systematically work through the Directorate appraisal action plans in order to understand any underlying issues and ascertain progress towards the target date of December 2016 for a minimum of 90% compliance. Support will be offered to all areas yet to achieve this level of compliance including further training where necessary.

Appraisal compliance is being discussed routinely at each Directorate business meeting to identify progress and challenges linked to appraisal completion. Staffing on the in-patient wards, in particular, remains a barrier to appraisal completion, data is now being captured on when booked appraisals have to be cancelled because of staffing levels to help future planning.

One Directorate is piloting a team-based appraisal/objective setting with selected teams (currently in maternity services and physiotherapy). This is an example of an initiative that, if successful, could help certain teams and staff groups reduce the time taken to complete appraisals and increase completion rates in future whilst not detracting from the quality of the appraisal process.

2.0 STRATEGIC UPDATE

2.1 West Yorkshire Sustainability and Transformation Plan (WYSTP)

Since the last report to the Board of Directors substantial progress has been made on developing a Sustainability and Transformation Plan for West Yorkshire and Harrogate. This will be submitted on 21 October in line with the National Timeline. The plan describes the approach being taken to address the triple aims of the Five Year Forward view at both a system level (West Yorkshire and Harrogate) and a local level (Harrogate and Rural District).

Key points to note:

- Collaborative working at West Yorkshire level will focus on Cancer services; Urgent and emergency care; Specialist services; Hyper acute stroke; Mental health and Prevention;

- There are also key STP level work streams focusing on standardisation of commissioning policies, acute collaboration and Primary and Community services;
- The opportunities for quality and efficiency improvements through acute collaboration are critically dependant on improvements in 'out of hospital care' which will target reduction in delayed transfers of care;
- The 'do nothing' scenario across health and social care is a financial gap of circa £1bn by 2020/21;
- The collective actions of the 'do something' scenarios brings the NHS back in to balance if all Sustainability and Transformation (S&T) funding is received, but leaves a circa £135m gap in social care funding across social care. Work continues to identify further mitigations;
- The Harrogate STP describes the system vision which encompasses self-care, prevention and early intervention; integrated, expanded community-based teams capable of supporting the person's needs holistically; a system approach to reducing demand and variation in elective care; and redesigning the way services are commissioned. It flags a level of financial risk in the system this year which if not fully mitigated, will impact on future years.

Whilst STPs have no statutory status there is a national expectation that operating plans and contracts will reflect the ambition of the STP. Further public engagement and/or consultation will be implemented where applicable.

2.2 Urgent and Emergency Care (U&EC) Acceleration Zone

The Chief Operating Officer (COO) has been progressing work with COO peers to agree what actions would be required in order to achieve the ambition of delivering the Emergency Department (A&E) 95% 4-hour waiting time standard at West Yorkshire level by March 2017. It is clear that substantial resources, both capital and revenue, would be required urgently if this very challenging objective is to be met.

A further verbal update will be provided at the meeting.

2.3 Care Quality Commission (CQC) Report and Action Plan

The CQC has confirmed that our action plan is satisfactory. Work continues to ensure that all outstanding actions relating to the 'Requires Improvement' rating for the safety domain are completed in a timely manner. This work is being overseen by the Senior Management Team and a progress update will be reported to the Quality Committee.

3.0 NATIONAL COMMUNICATIONS RECEIVED AND ACTED UPON

3.1 Strengthening financial performance & accountability in 2016/17: next steps and taking further action to reduce agency spending

A letter was received from NHS Improvement on 7 October following the publication of the document "Strengthening Financial Performance and Accountability in the NHS". This was followed by information received by all Trusts from NHS Improvement on 17th October, regarding further actions needed to reduce agency spending. An element of these requirements is ensuring that steps are taken to ensure Boards are holding executive directors to account to reduce excess costs associated with agency spending, informed by high quality information.

As a result the Board are required to complete a self-certification checklist to be assured that the Trust is taking all appropriate actions on agency spending and to identify additional steps to take. The checklist includes actions that can have an immediate impact: establishing governance,

accessing accurate and timely data to inform your decisions and using appropriate tools and processes – such as rapid recruitment processes and e-Rostering.

The completed checklist is due for submission to NHS Improvement on 30 November. The Executive Team are reviewing the checklist on 21 October and the completed checklist will be circulated prior to the Board meeting on 30 November to enable appropriate Board approval.

3.2 2016/17 and 2017/18 control total

The Trust has received notification of its control total for 2017/18 and 2018/19. The £1.8 billion Sustainability and Transformation Fund (STF) is conditional on the NHS provider sector delivering a minimum of break even in 2017/18 and 2018/19. To ensure this is the case, every provider will need to deliver an agreed financial control total in 2017/18 and 2018/19. Agreement to and delivery of the control total is a core part of NHS Improvement's new oversight regime.

We are required to accept or decline the offer by 24 November. Performance against agency cap is a key requirement and key part of the SOF. Access to a maximum of 30% of a provider's STF allocation is conditional on it maintaining delivery of core access standards through 2017/18 and 2018/19.

HDFT will receive £3.8m of STF money in 17/18 and 18/19 if we deliver a surplus of our own of £2.4m in 17/18 and £2.9m in 18/19. The required control totals are therefore £6.2m in 2017/18 and £6.7m in 2018/19.

4.0 WORKING IN PARTNERSHIP

4.1 Harrogate Clinical Board: Elective Care Rapid Testing Programme

The Elective Care Rapid Testing programme has now reached the end of the 100 day period. The Clinical Board will now have a key role to play in taking forward plans which will support Harrogate and Rural District CCGs financial recovery plan. The Trust has put in place a range of actions designed to support the CCGs recovery plan. Clinicians will work collaboratively over the coming weeks to ensure that these steps do not compromise patient safety or professional accountability.

4.2 Harrogate Health Transformation Board (HHTB)

The Harrogate Health Transformation Board met on 22th September and welcomed Penny Jones as the new independent Chair for the Board. Penny aims to bring constructive challenge to the group and help it develop its ability to think and act as a whole system.

The cross-West Yorkshire finance submission was made on the 16th September. The current financial gap is £45m, but it was acknowledged that this was likely to grow, reflecting the current pressure in the health and care system.

A West Yorkshire networking event connecting the STP and emerging new care models will take place on 21st October, to explore the development of whole population health and care models, reducing urgent demand, extending the role of primary care and community services, technology solutions to support change, improving patient experience, direct booking, value for money and return on investment, collaborative leadership, governance and capability for change.

Other areas of focus and discussion at the meeting included:

- The development of a Memorandum of Understanding, setting out the purpose and intentions of the partnership and the ways of working to achieve its objectives;
- Financial position and impact for the local system and associated recovery plans;
- The recent funding award for the Estates and Technology Transformation Fund to support the partnership to secure shared building to enable teams to co-locate and work better together and also to ensure that we have the right IT infrastructure to support this;
- Programme engagement and communications development including the production of a short film showing the work of the Community Care Teams at the centre of the new care model.

The Key Messages from September meeting is available in the Boardpad Reading Room.

4.3 West Yorkshire Association of Acute Trusts (WYAAT)

WYAAT Chief Executive Officers held a time out session on 18 October to discuss future collaboration, system governance and the draft STP.

There is a need to progress to a more formal governance arrangement in order to achieve the level of ambition describe in the STP. Steps to reduce clinical variation have the potential to realise considerable quality improvements, as well as financial savings, and these now need to be worked up in more detail.

All Trusts have considered the options for collaboration and supported in principle the creation of a Committee in Common. A formal Memorandum of Understanding is under development and this proposition will be discussed at a meeting of Chairs and Chief Executive's later this month.

The group received a presentation from colleagues working in South Yorkshire on developments associated with their STP. Progress at the required pace in the West Yorkshire and Harrogate STP will require additional investment in the WYAAT Project Management Office function.

5.0 FINANCIAL POSITION

The reported position at the end of Month 6 (September) is that we have achieved our financial plan. Before Sustainability and Transformation (S&T) funding, we have a year to date surplus of £0.6m, which when combined with the S&T funding of £2.3m (£1.15m per quarter) means we are reporting a surplus of £2.9m. This is a significant achievement for the Trust and means we will receive the second tranche of S&T funding.

Some one-off actions were taken in September, but the operational run rate has also improved in September, with activity being higher than previous months and our ward expenditure variance reducing. This reflects the hard work and commitment of the Directorates over the last two months.

Further detail is contained within the report from the Finance Director.

6.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 19th October and key issues discussed and for noting by the Board of Directors are as follows:

- There have been 21 cases of Clostridium Difficile year to date. Approaches to screening vary between providers but the high rate of testing and high rate of case finding makes Harrogate an outlier when compare to peers. The reasons for this require more investigation. The

executive team will be meeting with the Director of Infection Prevention and Control to discuss further actions to be taken;

- Financial performance has improved significantly since the SMT meeting in August which had a specific focus on financial recovery, with all three areas of adverse variance (income, ward pay and Cost Improvement Plans) improved. The September plan was achieved and the Trust has secured the Sustainability and Transformation Funding payment for Quarter 2;
- The Quarter 2 Governance rating relating to our performance standards is confirmed as Green and will be submitted to NHS Improvement on 30 November;
- SMT received a presentation on the approach to developing the Trust's Clinical Workforce Strategy and progress to date. A draft of the Strategy will be discussed at the Board development session on 26 October and will be submitted to the November meeting of the Board of Directors for approval;
- SMT discussed NHS Improvement guidance on managing medical locum costs and arrangements for managing this internally. The Director of Workforce and Organisational Development has been identified as the executive lead for driving down medical locum costs and the Chief Operating Officer oversees day to day sign off. The Medical Director will have an enhanced role in future arrangements;
- The CCGs financial recovery plan was discussed. All directorates will be taking urgent actions to help curtail costs without compromising patient safety or attainment of the Trust Control Total;
- Progress on achieving improved compliance with appraisals was noted and a further update is provided in section 1.3; and
- The Hospital Pharmacy and Medicines Optimisation Transformation Plan (HPTP) was approved.

The Minutes from SMT meetings are available in the BoardPad Reading Room.

7.0 BOARD ASSURANCE AND CORPORATE RISK

The summary current position of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) is presented below. There will be an opportunity to discuss both the BAF and CRR during the confidential session of the Board, due to the detail of their content. The full BAF is available for Board members in the BoardPad Reading Room.

7.1 Board Assurance Framework (BAF)

The BAF was reviewed by the Executive Directors during week commencing 17th October. Although no risks have been removed, all BAF entries have action plans to address the gaps in controls and all action plans have progress scores of 1 or 2, providing assurance that actions to mitigate existing gaps in controls are being progressed. A review of key controls has been undertaken as a result of the completion of actions, and additional actions have been added to mitigate increased levels of risk, where appropriate.

Changes to the Board Assurance Framework since September

New risks

Following concerns raised by the Board of Directors at the September meeting of the Board, the Board are asked to note and agree the inclusion of a new risk (BAF# 6) to reflect the impact of sustainability and transformation planning in terms of risk to senior leadership capacity.

Changes to residual risk scores

There have been no changes to the residual risk scores since the September report.

Summary

Three risks (BAF numbers 2, 12, and 13) are currently assessed as having achieved their target risk score. There are six strategic risks (BAF numbers 1, 4, 9, 12, 14 and 15) which are assessed at a risk score of 'Red' 12. No BAF entries have scores greater than 12. The strategic risks are as follows:

Ref	Description	Risk score	Progress score
BAF 1	Risk of a lack of medical, nursing and clinical staff	Red 12 ↔	Unchanged at 1
BAF 2	Risk of a high level of frailty in the local population	Amber 8 ↔	Unchanged at 2
BAF 3	Risk of a failure to learn from feedback and Incidents	Amber 9 ↔	Unchanged at 2
BAF 4	Risk of a lack of integrated IT structure	Red 12 ↔	Unchanged at 1
BAF 5	Risk of maintaining service sustainability	Amber 8 ↔	Unchanged at 2
BAF 6	Risk to senior leadership capacity	Amber 9	1 – new risk
BAF 9	Risk of a failure to deliver the Operational Plan	Red 12 ↔	Unchanged at 2
BAF 10	Risk of breaching the terms of the Trust's Licence to operate	Amber 10 ↔	Unchanged at 2
BAF 12	Risk of external funding constraints	Red 12 ↔	Unchanged at 2
BAF 13	Risk of a reduced focus on quality	Yellow 4 ↔	Unchanged at 1
BAF 14	Risk of delivery of integrated models of care	Red 12 ↔	Unchanged at 2
BAF 15	Risk of misalignment of strategic plans	Red 12 ↔	Unchanged at 1
BAF 16	Risk that the Trust's critical infrastructure is not fit for purpose	Amber 8 ↔	Unchanged at 1

Key to progress score on actions:

1. Fully on plan across all actions
2. Actions defined – some progressing, where delays are occurring, interventions are being taken
3. Actions defined – work commenced
4. Actions defined – work not yet commenced/behind plan

7.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meetings of the Corporate Risk Review Group on 14th October. The Corporate Risk Register contains thirteen risks. Changes to the CRR since the September meeting of the Board of Directors are:

New Risks

CR15 - risk to reputation of the Wheelchair service and the Trust due to delays in securing equipment due to a lack of funding was escalated to the Corporate Risk Register with a score of 'Red' 12.

CR16 – clinical risk due to delays in ordering community and wheelchair equipment due to financial constraints was escalated to the Corporate Risk Register with a score of 'Red' 12.

CR17 – risk of harm to ophthalmology patients as a result of being lost to follow up was escalated to the Corporate Risk Register with a score of 'Red' 12.

Changes to the Corporate Risk Register

The risk score for CR9: risk to the sustainability of service delivery and acute rotas due to withdrawal of trainees in Medicine by GMC/HEEYH due to failure to adhere to the conditions set following the annual quality management visit and subsequent triggered visit, was reduced to C4 x L3 = 12. Progress score has improved to 2.

The risk score for CR11 remained the top scoring risks at Red 16: CR11: Financial and Regulatory risk due to non-compliance with agency cap rules. Risks CR12, CR15, CR16 and CR17 have reported actions behind plan with the progress score of 3.

Dr Ros Tolcher
Chief Executive
October 2016

Report to the Trust Board of Directors: 26 October 2016	Paper No: 7.0
Title	Integrated Board Report
Sponsoring Director	Dr Ros Tolcher, Chief Executive
Author(s)	Ms Rachel McDonald, Head of Performance & Analysis
Report Purpose	To provide the Board with an update on performance relating to: operational performance; quality; and finance and efficiency.
Key Issues for Board Focus:	
<p>The Trust is required to report its operational performance to NHS Improvement and to routinely submit performance data to NHS England and Harrogate and Rural District CCG. The Board of Directors are asked to note that:</p> <ul style="list-style-type: none"> • HDFT's Trust level performance on the A&E 4-hour standard improved to 96.2% in September. This means that the 95% standard has been delivered for Quarter 2 with overall quarter performance of 95.3%. • There were 4 cases of hospital acquired C.difficile reported in September bringing the year to date total to 17. Of these, 13 have now had root cause analysis (RCA) completed and agreed with HARD CCG. Of these, 4 have been determined to be due to a lapse in care and 9 not due to a lapse in care. The Trust's C. difficile trajectory for the full year 2016/17 is a maximum of 12 cases due to lapses in care. • The Trust delivered the financial plan for Quarter 2 and therefore will receive the second allocation of S&T funding (£1.15m). • The latest published national data on incident reporting showed that Acute Trusts reported an average ratio of 34 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's local reporting ratio for the same period was 18 which places the Trust in the bottom 25% nationally. • Delayed transfers of care increased to 5.8% when the snapshot was taken in September, which is the highest figure reported for some time. • Two new metrics have been added to the report this month looking at electronic staff rostering via Rosterpro. 	
Related Trust Objectives	
To deliver high quality care	Yes – the report triangulates key performance metrics covering quality, finance and efficiency and operational performance, presenting trends over time to enable identification of improvements and deteriorations in the delivery of high quality care.
To work with partners to deliver integrated care	Yes – key performance metrics allow the Board to receive assurance in terms of the delivery of high quality care, often underpinned by collaboration and partnership working, particularly when developing new care models.
To ensure clinical and financial sustainability	Yes – the report provides the Board with assurance on progress of work across the region to ensure clinical and financial sustainability.
Risk and Assurance	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF# 1: risk of a lack of medical, nursing and clinical staff; BAF# 2: risk of a high level of frailty in local population; BAF# 9: risk of failure to deliver the operational plan; and BAF# 12: external funding constraints.
Legal/regulatory implications	The report does not highlight any legal/regulatory implications for the period.
Action Required by the Board of Directors	
The Board of Directors are asked to receive and note the content of the report.	

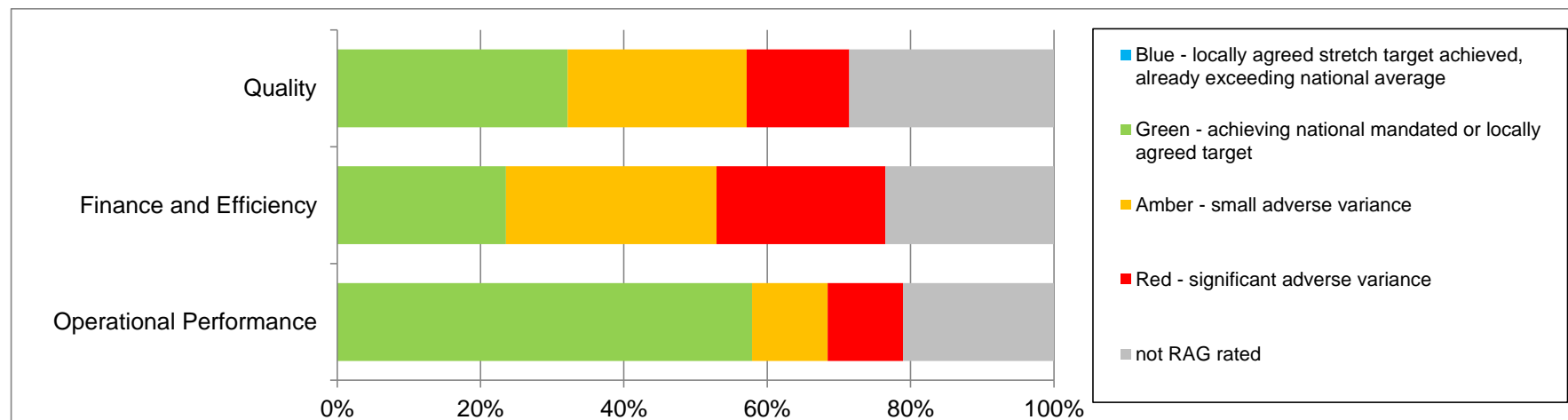
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Integrated board report - September 2016

Key points this month

1. HDFT's Trust level performance on the A&E 4-hour standard improved to 96.2% in September. This means that the 95% standard has been delivered for Quarter 2 with overall quarter performance of 95.3%.
2. There were 4 cases of hospital acquired C.difficile reported in September bringing the year to date total to 17. Of these, 13 have now had root cause analysis (RCA) completed and agreed with HARD CCG. Of these, 4 have been determined to be due to a lapse in care and 9 not due to a lapse in care. The Trust's C. difficile trajectory for the full year 2016/17 is a maximum of 12 cases due to lapses in care.
3. The Trust delivered the financial plan for Quarter 2 and therefore will receive the second allocation of S&T funding (£1.15m).
4. The latest published national data on incident reporting showed that Acute Trusts reported an average ratio of 34 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's local reporting ratio for the same period was 18 which places the Trust in the bottom 25% nationally.
5. Delayed transfers of care increased to 5.8% when the snapshot was taken in September, which is the highest figure reported for some time.
6. Two new metrics have been added to the report this month looking at electronic staff rostering via Rosterpro.

Summary of indicators



Quality - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Safety thermometer - harm free care	Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.		<p>The harm free percentage for September was 94.6%, a decrease from 97.3% in the previous month but above the latest national average of 94.2%.</p> <p>The main reason for the decrease in performance was due to an increase in the number of old pressure ulcers (present on admission/commencement of care or developed within 72 hours) reported on this month's survey, with 23 compared to 13 last month.</p>	
Pressure ulcers - hospital acquired	The chart shows the cumulative number of category 3 or category 4 hospital acquired pressure ulcers in 2016/17. The data includes hospital teams only.		<p>There were 3 hospital acquired category 3 pressure ulcer reported in September. In the year to date, 16 hospital acquired category 3 or category 4 pressure ulcers have been reported. Of these, 6 were deemed to be avoidable, 5 unavoidable and 5 cases are still under root cause analysis (RCA).</p> <p>The Trust has set a local trajectory for 2016/17 of zero avoidable hospital acquired category 3 or category 4 pressure ulcers.</p>	
	This chart has been amended this month to also include category 2 hospital acquired pressure ulcers, as well as category 3 / category 4. The data includes hospital teams only.		<p>The number of hospital acquired category 2-4 pressure ulcers reported in 2016/17 to date is 91. This compares to 81 in the same period last year.</p> <p>A maximum trajectory for 2016/17 of 155 cases of category 2-4 hospital acquired pressure ulcers has been agreed via the Quality Committee.</p>	
Pressure ulcers - community acquired	The chart shows the cumulative number of category 3 or category 4 community acquired pressure ulcers in 2016/17. This metric includes all pressure ulcers identified by community teams including pressure ulcers already present at the first point of contact.		<p>There were 8 community acquired category 3 pressure ulcers reported in September. In the year to date, 45 community acquired category 3 or category 4 pressure ulcers have been reported. Of these 45 cases, 15 were deemed to be avoidable, 11 unavoidable and 19 cases are still under root cause analysis (RCA).</p> <p>A maximum trajectory for the number of category 2-4 community acquired pressure ulcers was agreed at the Quality Committee and will be based on a 20% reduction against the number of cases reported in 2015/16.</p>	

Quality - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Falls	The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good.		<p>The rate of inpatient falls was 6.4 per 1,000 bed days in September, an increase on previous months but remaining below the HDFT 2015/16 average rate.</p> <p>The falls sensors are now in place on Byland, Jervaulx, Farndale and Trinity wards and there is a plan to roll out to the other ward areas by November.</p>	
Falls causing harm	The number of inpatient falls causing significant harm, expressed as a rate per 1,000 bed days. The data includes falls causing moderate harm, severe harm or death. A low rate is good.		<p>The rate of inpatient falls causing moderate harm, severe harm or death was 0.12 per 1,000 bed days in September, a decrease on the previous month and below the average HDFT rate for 2015/16.</p> <p>There have been 6 inpatient falls causing moderate or severe harm in 2016/17 to date, all of which resulted in a fracture. This compares to 9 moderate or severe harm falls in the same period last year.</p>	
Infection control	The chart shows the cumulative number of hospital acquired C. difficile cases during 2016/17. HDFT's C. difficile trajectory for 2016/17 is 12 cases, no change on last year's trajectory. Cases where a lapse in care has been deemed to have occurred would count towards the Monitor risk assessment framework. Hospital acquired MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2016/17. The last reported case of hospital acquired MRSA at HDFT was in Oct-12.		<p>There were 4 cases of hospital acquired C. difficile reported in September, bringing the year to date total to 17 cases. All 17 cases have now have root cause analysis (RCA) completed by HDFT and 13 of the RCAs have been discussed and agreed with HARD CCG. Of the 13 cases discussed and agreed, 4 have been determined to be due to a lapse in care and 9 were determined to not be due to a lapse in care. No cases of hospital acquired MRSA have been reported in 2016/17 to date.</p>	
Avoidable admissions	The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.		<p>There were 182 avoidable admissions in August, a decrease on last month and below the HDFT average. There is some seasonality in this metric so a reduction during the summer months is expected. However this is lower than the level in the same period last year.</p> <p>An extra line has been added to the chart to show the number of avoidable admissions excluding CAT (Clinical Assessment Team) attendances and admissions aged 0-17 years. This allows us to isolate and track the adult emergency admissions that may be avoided by the New Care Model.</p>	

Quality - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality
<p>Reducing readmissions in older people</p>	<p>The chart shows the proportion of older people aged 65+ who were still at home 91 days after discharge from hospital into rehabilitation or reablement services. A high figure is good. <i>This indicator is in development.</i></p>		<p>For patients discharged in June, 75% were still in their own home at the end of September, a decrease on the previous month.</p> <p>Following a deterioration in performance on this metric earlier this year, a case note audit of a sample of patients is being carried out to understand any themes and actions required and the results will be reported by Long Term and Unscheduled Care Directorate in the Autumn.</p>	
<p>Mortality - HSMR</p>	<p>The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.</p>		<p>HDTF's HSMR decreased to 101.34 in July and remains within expected levels. At specialty level, 2 specialties (Geriatric medicine and Gastroenterology) have a standardised mortality rate above expected levels.</p>	
<p>Mortality - SHMI</p>	<p>The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.</p>		<p>HDTF's SHMI increased to 95.23, compared to 94.37 last month. However this remains below the national average and within expected levels.</p> <p>At specialty level, 2 specialties (Geriatric Medicine and Gastroenterology) have a standardised mortality rate above expected levels.</p>	
<p>Complaints</p>	<p>The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.</p>		<p>18 complaints were received in September compared to 25 last month, with none classified as amber or red. This is just above the 2015/16 average.</p>	

Quality - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Incidents - all	<p>The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services.</p> <p>A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture</p>		<p>The latest published national data shows that Acute Trusts reported an average ratio of 34 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's local reporting ratio for the same period was 18 which places the Trust in the bottom 25% nationally. There was an increase in moderate harm incidents reported by HDFT during this period - reasons for this are known and include the fact that duty of candour was introduced in this period and there was a change in the way staff assessed severity.</p>	
Incidents - SIRIs and never events	<p>The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services.</p> <p>We have changed this indicator to now include both comprehensive and concise SIRIs and have amended the presentation to show a cumulative position.</p>		<p>There were no comprehensive SIRIs and no never events reported in September.</p> <p>There have been 67 concise SIRIs and 2 comprehensive SIRIs reported in the year to date. In 2015/16, HDFT reported an average of 9.6 SIRIs per month.</p>	
Friends & Family Test (FFT) - Staff - % recommend as a place to work	<p>The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in.</p> <p>The chart shows the percentage of staff that would recommend the Trust as a place to work. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally which would typically mean that 71% of staff would recommend the Trust as a place to work.</p>		<p>In Quarter 2, 70.4% of HDFT staff surveyed would recommend HDFT as a place to work, this remains above the most recently published national average of 64%.</p> <p>The Staff Friends and Family Test is now surveying the whole Trust rather than by Directorate. This will allow us to benchmark our response rate. During 2015/16, the whole Trust was only surveyed during Quarter 3.</p>	
Friends & Family Test (FFT) - Staff - % recommend as a place to receive care	<p>The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in.</p> <p>The chart shows the percentage of staff that would recommend the Trust as a place to receive care. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally which would typically mean that 88% of staff would recommend the Trust as a place to work.</p>		<p>In Quarter 2, 87.3% of HDFT staff surveyed would recommend HDFT as a place to receive care. This is an increase on Q1 and above the most recently published national average of 80%.</p> <p>The Staff, Friends and Family Test is now surveying the whole Trust rather than by Directorate. This will allow us to benchmark our response rate. During 2015/16, the whole Trust was only surveyed during Quarter 3.</p>	

Quality - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Friends & Family Test (FFT) - Patients	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.		<p>94.3% of patients surveyed in September would recommend our services, a slight reduction on last month but remaining above the latest published national average.</p> <p>The technical problems with the automated phone call service were fixed in August and phone calls reinstated to all services that were previously using them.</p>	
Safer staffing levels	Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website.		<p>Overall staffing compared to planned was at 102% in September. CSW staffing remains high compared to plan - this is reflective of the increased need for 1-1 care for some inpatients.</p> <p>A significant focus is being placed on recruitment of RN staff including open events and targeted recruitment campaigns including the use of social media. The Trust is also participating the Global Health Exchange Programme which will enable the Trust to recruit RNs from India who will work in the Trust for 3 years developing their nurse education and skills. The RNs will then return to India to utilise their skills and further develop the Indian health economy.</p>	
Electronic rostering timeliness	The chart shows the proportion of rosters that were published on time on Rosterpro (at least 4 weeks before the roster start date). It includes data for 20 specific clinical areas (mostly inpatient wards) involved in the pilot phase. Data presented is for a rolling 12 months period and is split by Clinical Directorate. A high percentage is good.		<p>This is the first time that this metric has been presented. Overall, 22% of rosters were published on time during the period May to September 2016. CCWCC and PSC Directorates have shown consistent improvement in the number of rosters being published on time. LTUC directorate's performance remains static and was at 6% in September to date.</p>	
Electronic rostering hours owed	This metric shows the sum of unused hours for staff as a running balance from the Trust's predefined audit start date. To allow for some flexibility in assigning hours over rosters (ie. for Night workers), an alert will be triggered when staff owe 30 hours or more. Data is split by Clinical Directorate for 20 specific clinical areas (mostly inpatient wards) involved in the pilot phase. A low number is good.		<p>This is the first time that this metric has been presented. The number of unused hours has been reducing since July. There have been significant improvements in data quality within the Rosterpro system during this period.</p>	

Quality - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality																		
Staff appraisal rates	<p>The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good.</p> <p>The figures from May 2016 onwards exclude employees currently on maternity leave, career break or suspension and staff who TUPE transferred into the organisation from Darlington, Durham and Middlesbrough from 1st April 2016.</p>		<p>The appraisal rate for the 12 months up to the end of September is 71.2%, a decrease of 2.1% from August. PSC Directorate currently has the lowest compliance rate of all Directorates within the Trust at 63.8%. The data cleansing is ongoing for the Durham, Darlington and Middlesbrough teams who transferred on 1 April 2016; the information for these areas will continue to be reported separately until the data cleansing process has completed. As at the end of September, 63.8% of DDM staff had recorded appraisals. Operational Directors are meeting throughout October in order to review the progress of action plans designed to deliver 90% compliance by December.</p>																			
Mandatory training rates	<p>The table shows the most recent training rates for all mandatory elements for substantive staff. The table excludes staff who TUPE transferred into the organisation on 1st April 2016. A high percentage is good.</p>	<table border="1"> <thead> <tr> <th>Competence Name</th> <th>% Completed</th> </tr> </thead> <tbody> <tr><td>Equality, Diversity and Human Rights - Level 1</td><td>92</td></tr> <tr><td>Fire Safety Awareness</td><td>90</td></tr> <tr><td>Infection Prevention & Control 1</td><td>99</td></tr> <tr><td>Infection Prevention & Control 2</td><td>82</td></tr> <tr><td>Information Governance: Introduction</td><td>86</td></tr> <tr><td>Information Governance: The Beginners Guide</td><td>81</td></tr> <tr><td>Prevent Basic Awareness (December 2015)</td><td>99</td></tr> <tr><td>Safeguarding Children & Young People Level 1 - Introduction</td><td>93</td></tr> </tbody> </table>	Competence Name	% Completed	Equality, Diversity and Human Rights - Level 1	92	Fire Safety Awareness	90	Infection Prevention & Control 1	99	Infection Prevention & Control 2	82	Information Governance: Introduction	86	Information Governance: The Beginners Guide	81	Prevent Basic Awareness (December 2015)	99	Safeguarding Children & Young People Level 1 - Introduction	93	<p>The data shown is for the end of September and excludes the staff who were TUPE transferred into the organisation on the 1st April 2016. The overall training rate for mandatory elements for substantive staff in this group is 91%.</p> <p>The new follow up procedure is now in place for Directorates to use and we hope to see a positive impact on compliance going forward.</p>	
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Sickness rates	<p>Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%. A low percentage is good.</p>		<p>The sickness rate for August is 3.96%, above the Trust threshold of 3.90%. Gastrointestinal problems continued to be the leading cause for sickness absence during August. CCWCC Directorate continue to have the highest rate for sickness within the directorates, recording 4.62% for August. The HR team remains focused on attendance management across the Trust, particularly in relation to the resolution of long term sickness cases. Flu jabs are currently being administered across the Trust with the aim of combating cough, cold and flu related absence.</p>																			

Quality - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Temporary staffing expenditure - medical/nursing /other	The chart shows staff expenditure per month, split into contracted staff, overtime and additional hours and temporary staff. Lower figures are preferable. <i>The traffic light criteria applied to this indicator is currently under review.</i>		The proportion of spend on temporary staff during September was 4.1%, a significant reduction when compared to 7.6% during 2015/16.	✓
Staff turnover rate	The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.		Voluntary turnover comprised 8.3% of the overall figure of 11.6%, a reduction of 0.2% on the previous month. The reduction of voluntary turnover can be attributed to success of the recently implemented Retention strategy. A presentation was undertaken at the Retention group in October detailing the findings of a study that our Graduate Trainee undertook in relation to nursing retention across the generations. Key findings have been presented for consideration and action by the group.	✓
Maternity - Caesarean section rate	The caesarean section rate is determined by a number of factors including ability to provide 1-1 care in labour, previous birth experience and confidence and ability of the staff providing care in labour. The rate of caesarean section can fluctuate significantly from month to month - as a result we have amended the presentation of this indicator this month to show a 12 month rolling average position.		HDFT's C-section rate for the 12 months ending September 2016 was 28.3% of deliveries, an increase on last month and remaining higher than average. The major contributing factor to the recent upward trend appears to be a significant increase in elective caesarean sections, with the emergency caesarean section rate remaining static and within expected parameters.	✓
Maternity - Rate of third and fourth degree tears	Third and fourth degree tears are a source of short term and long term morbidity. A previous third degree tear can increase the likelihood of a woman choosing a caesarean section in a subsequent pregnancy. Recent intelligence suggested that HDFT were an outlier for third degree tears with operative vaginal delivery. Quality improvement work is being undertaken to understand and improve this position and its inclusion on this dashboard will allow the Trust Board to have sight of the results of this.		The rate of third or fourth degree tears was 2.4% of deliveries in the 12 month period ending September 2016, remaining well below previous months. The rolling 12 months rate is at its lowest point since the dashboard was created. This may reflect the significant amount of quality improvement work aimed at reducing the incidence of third degree tears.	✓

Quality - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality																																																
<p>Maternity - Unexpected term admissions to SCBU</p>	<p>This indicator is a reflection of the intrapartum care provided. For example, an increase in the number of term admissions to special care might reflect issues with understanding of fetal heart rate monitoring in labour. We have amended the presentation of this indicator this month to show a 12 month rolling average position.</p>	<table border="1"> <caption>Approximate data from the trend chart</caption> <thead> <tr> <th>Month</th> <th>No. admissions</th> <th>HDFT mean</th> </tr> </thead> <tbody> <tr><td>Apr-14</td><td>5.5</td><td>4.3</td></tr> <tr><td>Jun-14</td><td>6.0</td><td>4.3</td></tr> <tr><td>Aug-14</td><td>5.0</td><td>4.3</td></tr> <tr><td>Oct-14</td><td>5.5</td><td>4.3</td></tr> <tr><td>Dec-14</td><td>5.5</td><td>4.3</td></tr> <tr><td>Feb-15</td><td>5.5</td><td>4.3</td></tr> <tr><td>Apr-15</td><td>6.0</td><td>4.3</td></tr> <tr><td>Jun-15</td><td>6.5</td><td>4.3</td></tr> <tr><td>Aug-15</td><td>7.0</td><td>4.3</td></tr> <tr><td>Oct-15</td><td>7.0</td><td>4.3</td></tr> <tr><td>Dec-15</td><td>6.5</td><td>4.3</td></tr> <tr><td>Feb-16</td><td>6.0</td><td>4.3</td></tr> <tr><td>Apr-16</td><td>5.5</td><td>4.3</td></tr> <tr><td>Jun-16</td><td>5.0</td><td>4.3</td></tr> <tr><td>Aug-16</td><td>4.5</td><td>4.3</td></tr> </tbody> </table>	Month	No. admissions	HDFT mean	Apr-14	5.5	4.3	Jun-14	6.0	4.3	Aug-14	5.0	4.3	Oct-14	5.5	4.3	Dec-14	5.5	4.3	Feb-15	5.5	4.3	Apr-15	6.0	4.3	Jun-15	6.5	4.3	Aug-15	7.0	4.3	Oct-15	7.0	4.3	Dec-15	6.5	4.3	Feb-16	6.0	4.3	Apr-16	5.5	4.3	Jun-16	5.0	4.3	Aug-16	4.5	4.3	<p>The chart shows the number of babies born at greater than 37 weeks gestation who were admitted to the Special Care Baby Unit (SCBU). The maternity team carry out a full review of all term admissions to SCBU.</p> <p>There were 2 term admissions to SCBU in September. The average number per month over the last 12 months is 4.3.</p>	
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Finance and Efficiency - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Readmissions	% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.		<p>The number of readmissions increased in August, when expressed as a percentage of all emergency admissions. The rate is above the average rate for 2015/16.</p> <p>HDFT and HARD CCG will be undertaking an audit of readmissions in Quarter 3 to determine the proportion of readmissions which were avoidable.</p>	
Readmissions - standardised	This indicator looks at the standardised readmission rate within 30 days. The data is standardised against various criteria including age, sex, diagnosis, comorbidities etc. The standardisation enables a more like for like comparison with other organisations. The national average is set at 100. A low rate is good - rates below 100 indicate a lower than expected readmission rate and rates above 100 indicate higher than expected readmission rate.		<p><i>This data has not been updated this month.</i></p> <p>HDFT's standardised readmission rate for the 12 month period ending May 2016 was 103.4 - above the national average but within expected levels.</p>	
Length of stay - elective	Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		<p>The average elective length of stay for September was 2.7 days, a decrease on the previous month. A focus on sustainably reducing this through the Planned Care Transformation programme is underway, which includes reducing the number of patients admitted the day before surgery.</p>	
Length of stay - non-elective	Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		<p>The average non-elective length of stay for September was 4.8 days, a decrease on the previous month and remaining below the HDFT average.</p>	


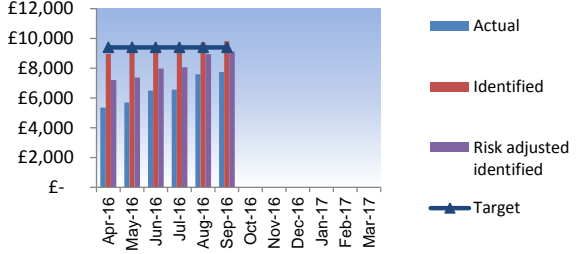

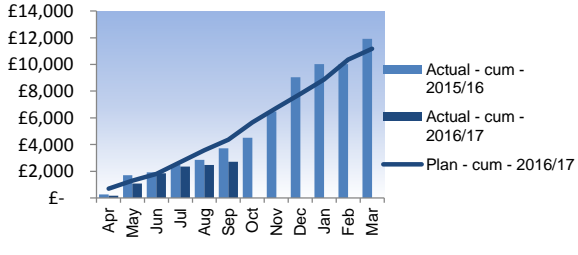

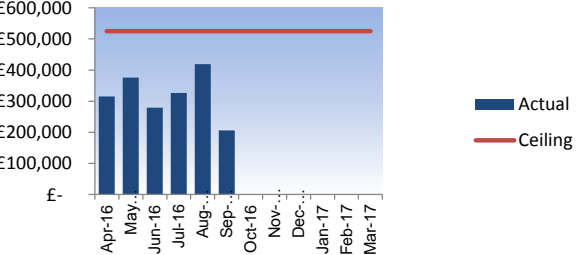

Finance and Efficiency - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Non-elective bed days	The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. A lower figure is preferable.		<p>Non-elective bed days for patients aged 18+ have been lower over the last few months and are in line with the 2016/17 trajectory. The decrease may be partly due to seasonality, although the reduction appears to be more marked than in the previous year.</p> <p>The 2016/17 trajectory is based on allowing for demographic growth and reducing by the non-elective reductions identified in the Value Proposition. For next month, an additional trajectory will be calculated taking into account the impact of targeted reductions in length of stay through the transformation programmes.</p>	
Theatre utilisation	The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of this. A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.		<p>Theatre utilisation decreased to 83.8% in September. However the number of cancelled sessions reduced to 6.3%.</p> <p>The agency cap is still impacting on theatre staffing and hence on utilisation.</p>	
Delayed transfers of care	The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable. A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG.		<p>Delayed transfers of care increased to 5.8% when the snapshot was taken in September, remaining above the maximum threshold of 3.5% set out in the contract.</p> <p>Further work to understand the reasons for this continued increase is being carried out by the Discharge Steering Group.</p>	
Outpatient DNA rate	Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance. A low percentage is good. Patient DNAs will usually result in an unused clinic slot.		<p>HDFT's DNA rate increased to 6.1% in July, a significant increase on previous months. This increase was seen across a number of specialties. However local data shows the DNA rate returning to normal in August and September.</p> <p>HDFT's DNA rate remains below that of both the benchmarked group of Trusts and the national average.</p>	

Finance and Efficiency - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Outpatient new to follow up ratio	The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.		<p>Reducing the number of follow ups is a major part of HARD CCG's financial recovery plan. HDFT's new to follow up ratio decreased in July and is now below both the national average and the benchmark group average.</p> <p>The Trust is working closely with HARD CCG on the Elective Rapid Testing Programme as part of the work of the Joint Clinical Board. The three specialties running the rapid testing programme all have reducing face to face follow ups as part of their ambition.</p>	✓
Day case rate	The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight. A higher day case rate is preferable.		<p>The day case rate decreased to 87.9% in September but remains within expected levels.</p>	✓
Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.		<p>The Trust reported a surplus of £2,927k for the year to the end of September, £38k ahead of plan. This position includes S&T funding of £2,300k.</p> <p>Recovery plans have had an impact in September, with the month being the highest level of acute income of the year to date, and the overspend on ward nursing reduced from £113k in August to £26k in September due to actions taken during the month. As a result of the positive performance (financially and performance standards achievement), the Trust will be eligible for the second quarter of S&T funding of £1.15m.</p>	✓
Cash balance	Monthly cash balance (£'000s)		<p>The Trust had a cash balance of £5.28m at the end of September. This is in line with our revised plan of £5.06m that we have submitted to NHS Improvement following agreement of our contract cash phasing profile with HARD CCG.</p>	✓


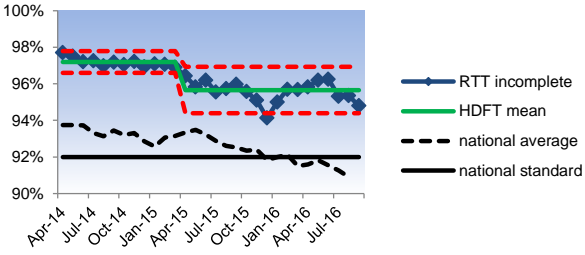

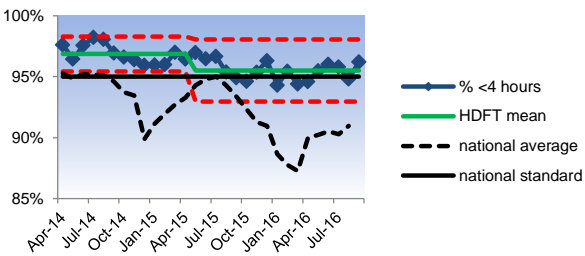

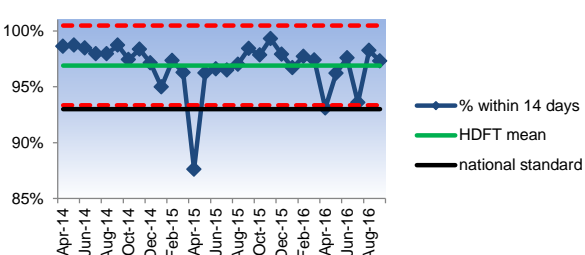

Finance and Efficiency - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality																		
NHS Improvement Financial Performance Assessment	From next month, the financial performance of providers will be assessed by NHS Improvement via the "Use of Resources Metrics (UOR)" comprising the following five metrics - Liquidity Ratio, Capital Servicing Capacity, I&E Margin, I&E Distance from Plan and Agency. For this month, the existing Financial Sustainability Risk Rating (FSRR) will be used.	<table border="1"> <thead> <tr> <th>Element</th> <th>Plan</th> <th>Actual</th> </tr> </thead> <tbody> <tr> <td>Capital Service Capacity rating</td> <td>4</td> <td>4</td> </tr> <tr> <td>Liquidity rating</td> <td>4</td> <td>4</td> </tr> <tr> <td>I&E Margin rating</td> <td>4</td> <td>4</td> </tr> <tr> <td>I&E Margin Variance rating</td> <td>3</td> <td>4</td> </tr> <tr> <td>Financial Sustainability Risk Rating</td> <td>4</td> <td>4</td> </tr> </tbody> </table>	Element	Plan	Actual	Capital Service Capacity rating	4	4	Liquidity rating	4	4	I&E Margin rating	4	4	I&E Margin Variance rating	3	4	Financial Sustainability Risk Rating	4	4	The Trust will report a risk rating of 4 for September.	
Element	Plan	Actual																				
Capital Service Capacity rating	4	4																				
Liquidity rating	4	4																				
I&E Margin rating	4	4																				
I&E Margin Variance rating	3	4																				
Financial Sustainability Risk Rating	4	4																				
CIP achievement	Cost Improvement Programme (CIP) performance outlines full year achievement on a monthly basis. The target is set at the internal efficiency requirement (£'000s). This indicator monitors our year to date position against plan.		79% of CIP schemes have been actioned to date. Plans are in place for 104% of the efficiency requirement, the risk adjusted total reduces to 97%.																			
Capital spend	Cumulative Capital Expenditure by month (£'000s)		Capital Expenditure was £1,652k behind plan at the end of September.																			
Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis as a percentage of total pay bill. The Trust aims to have less than 3% of the total pay bill on agency staff.		The agency bill for September was 1.7% of Trust pay expenditure. Expenditure remains below the agency ceiling set by NHS Improvement but is above the benchmark the Trust has set in month.																			

Finance and Efficiency - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality																											
<p>Research - Invoiced research activity</p>	<p>Aspects of research studies are paid for by the study sponsor or funder.</p>	<table border="1"> <caption>Estimated data from Trend Chart</caption> <thead> <tr> <th>Quarter</th> <th>Invoiced amount (cum) (£)</th> <th>Target (cum) (£)</th> </tr> </thead> <tbody> <tr> <td>Q1 2015/16</td> <td>~50,000</td> <td>~50,000</td> </tr> <tr> <td>Q2 2015/16</td> <td>~100,000</td> <td>~100,000</td> </tr> <tr> <td>Q3 2015/16</td> <td>~150,000</td> <td>~150,000</td> </tr> <tr> <td>Q4 2015/16</td> <td>~200,000</td> <td>~200,000</td> </tr> <tr> <td>Q1 2016/17</td> <td>~50,000</td> <td>~100,000</td> </tr> <tr> <td>Q2 2016/17</td> <td>~100,000</td> <td>~150,000</td> </tr> <tr> <td>Q3 2016/17</td> <td>~150,000</td> <td>~200,000</td> </tr> <tr> <td>Q4 2016/17</td> <td>~200,000</td> <td>~250,000</td> </tr> </tbody> </table>	Quarter	Invoiced amount (cum) (£)	Target (cum) (£)	Q1 2015/16	~50,000	~50,000	Q2 2015/16	~100,000	~100,000	Q3 2015/16	~150,000	~150,000	Q4 2015/16	~200,000	~200,000	Q1 2016/17	~50,000	~100,000	Q2 2016/17	~100,000	~150,000	Q3 2016/17	~150,000	~200,000	Q4 2016/17	~200,000	~250,000	<p><i>There is no update of this indicator this month.</i></p> <p>As set out in the Research & Development strategy, the Trust intends to maintain its current income from commercial research activity and NIHR income to support research staff to 2019. Each study is unique. Last year the Trust invoiced for a total of £223k.</p>	
Quarter	Invoiced amount (cum) (£)	Target (cum) (£)																													
Q1 2015/16	~50,000	~50,000																													
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Operational Performance - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality																																				
NHS Improvement governance rating	NHS Improvement use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the left shows how the Trust is performing against the national performance standards in the "access and outcomes metrics" section.	<table border="1"> <thead> <tr> <th>Indicator</th> <th>Q2 score</th> <th>Indicator</th> <th>Q2 score</th> </tr> </thead> <tbody> <tr> <td>18 weeks - incomplete</td> <td>0.0</td> <td>Cancer - 14 days</td> <td>0.0</td> </tr> <tr> <td>A&E - 4 hour standard</td> <td>0.0</td> <td>Cancer - 14 days - breast symptoms</td> <td>0.0</td> </tr> <tr> <td>Cancer - 62 days to treatment</td> <td>0.0</td> <td>C-Difficile</td> <td>0.0</td> </tr> <tr> <td>Cancer - 62 days to treatment - screening</td> <td>0.0</td> <td>MRSA</td> <td>0.0</td> </tr> <tr> <td>Cancer - 31 day subsequent treatment - surgery</td> <td>0.0</td> <td>Compliance with requirements regarding access to healthcare for patients with learning disabilities</td> <td>0.0</td> </tr> <tr> <td>Cancer - 31 day subsequent treatment - drugs</td> <td>0.0</td> <td>Community services data completeness - RTT information</td> <td>0.0</td> </tr> <tr> <td>Cancer - 31 day subsequent treatment - radiotherapy</td> <td>N/A</td> <td>Community services data completeness - Referral information</td> <td>0.0</td> </tr> <tr> <td>Cancer - 31 day first treatment</td> <td>0.0</td> <td>Community services data completeness - Treatment activity information</td> <td>0.0</td> </tr> </tbody> </table>	Indicator	Q2 score	Indicator	Q2 score	18 weeks - incomplete	0.0	Cancer - 14 days	0.0	A&E - 4 hour standard	0.0	Cancer - 14 days - breast symptoms	0.0	Cancer - 62 days to treatment	0.0	C-Difficile	0.0	Cancer - 62 days to treatment - screening	0.0	MRSA	0.0	Cancer - 31 day subsequent treatment - surgery	0.0	Compliance with requirements regarding access to healthcare for patients with learning disabilities	0.0	Cancer - 31 day subsequent treatment - drugs	0.0	Community services data completeness - RTT information	0.0	Cancer - 31 day subsequent treatment - radiotherapy	N/A	Community services data completeness - Referral information	0.0	Cancer - 31 day first treatment	0.0	Community services data completeness - Treatment activity information	0.0	<p>HDFT's governance rating for Quarter 2 is Green.</p> <p>17 cases of hospital acquired C.difficile have been reported in the year to date. Of these, 13 have now had root cause analysis (RCA) completed and agreed with HARD CCG - 4 have been determined to be due to a lapse in care. The Trust's C. difficile trajectory for the full year 2016/17 is a maximum of 12 cases due to lapses in care.</p>	
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RTT Incomplete pathways performance	Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks. A high percentage is good.		<p>94.8% of patients were waiting 18 weeks or less at the end of September, a decrease on last month but remaining above the required national standard of 92%.</p> <p>At specialty level, Trauma & Orthopaedics and Gastroenterology were below the 92% standard in September.</p>																																					
A&E 4 hour standard	Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%. The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good. Historical data for HDFT included both Ripon and Selby MIUs. In agreement with local CCGs, York NHSFT are reporting the activity for Selby MIU from 1st May 2015.		<p>HDFT's Trust level performance for September 2016 was 96.2%, an increase on last month and above the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. At a Trust level, performance for Quarter 2 overall was above the 95% standard at 95.6%.</p> <p>Performance for Harrogate ED was above the standard in September (95.3%) but below for the quarter overall (94.7%).</p>																																					
Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.		<p>Delivery at expected levels.</p>																																					

Operational Performance - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good.		Delivery at expected levels.	✓
Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good.		Delivery at expected levels.	✓
Cancer - 31 day wait for second or subsequent treatment: Surgery	Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good.		Provisional performance is below the required 94% standard in September with 2 breaches of the 31 day standard. However performance for Quarter 2 overall is above the standard at 94.7%.	✓
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good.		Delivery at expected levels.	✓

Operational Performance - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Cancer - 62 day wait for first treatment from urgent GP referral to treatment	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.		<p>Trust total delivery at expected levels.</p> <p>Of the 11 cancer sites treated at HDFT, 3 had performance below 85% in September - colorectal (3 breaches), head and neck (1 breach) and lung (1 breach).</p> <p>3 patients waited over 104 days for treatment in September. The main reasons for the delays were clinical complexity and patient choice.</p>	
Cancer - 62 day wait for first treatment from consultant screening service referral	Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good.		<p>Delivery at expected levels.</p>	
Cancer - 62 day wait for first treatment from consultant upgrade	Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good.		<p>One patient (0.5 accountable) was treated at Leeds in September after day 62. This means that for Quarter 2 there have been 4.5 treatments and 0.5 over 62 days giving a performance of 88.9%. However this will not be reportable as it is below the de minimis level of 5 pathways per quarter.</p>	
GP OOH - NQR 9	NQR 9 (National Quality Requirement 9) looks at the % of GP OOH telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation. A high percentage is good.		<p>Performance remains below the required 95% for this metric and was at 76% in September.</p> <p>Work continues with the Information Team to implement new, meaningful performance metrics and assure the quality of the data and reports from the Adastra system. The service is also undertaking a GP performance review which will provide further assurance as to the quality of the service provision.</p>	










Operational Performance - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality
GP OOH - NQR 12	NQR 12 (National Quality Requirement 12) looks at the % of GP OOH face to face consultations (home visits) started for urgent cases within 2 hours. The data presented excludes Selby and York as these do not form part of the HFT OOH service from April 2015. A high percentage is good.		<p><i>This indicator has not been updated this month.</i> Performance remains below the required 95% for this metric but has improved to 85% in August.</p> <p>Work continues with the Information Team to implement new, meaningful performance metrics and assure the quality of the data and reports from the Adastra system. The service is also undertaking a GP performance review which will provide further assurance as to the quality of the service provision.</p>	
Children's Services - 10-14 day new birth visit	The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good. Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level.		In September, 86% of babies in Darlington, 90% of babies in Co. Durham, 87% of babies in Middlesbrough and 78% of babies in North Yorkshire were recorded on Systmone as having had a new birth visit within 14 days of birth.	
Children's Services - 2.5 year review	The percentage of children who had a 2.5 year review. A high percentage is good. Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level.		In September, 89% of children in Darlington, 89% of children in Co. Durham, 85% of children in Middlesbrough and 74% of children in North Yorkshire were recorded on Systmone as having had a 2.5 year review.	
Community equipment - deliveries within 7 days	The number of standard items delivered within 7 days by the community equipment service. A high percentage is good.		Performance remains above expected levels.	

Operational Performance - September 2016

Indicator	Description	Trend chart	Interpretation	Data quality
CQUIN - dementia screening	The proportion of emergency admissions aged 75 or over who are screened for dementia within 72 hours of admission (Step 1). Of those screened positive, the proportion who went on to have an assessment and onward referral as required (Step 2 and 3). The operational standard is 90% for all 3 steps. A high percentage is good.		Delivery at expected levels.	✔
Recruitment to NIHR adopted research studies	The Trust has a recruitment target of 2,800 for 2016/17 for studies on the NIHR portfolio. This equates to 234 per month. Over recruitment is encouraged.		The year to date position on recruitment to research studies is 9% below plan, an improvement on the position reported last month. There are a number of issues that have impacted recruitment year to date including availability of suitable studies, changes in types of studies and also capacity within the research team. An increase in the availability of studies suitable for our population and additional capacity within the research team means that we are confident that we will be back on target by the end of the financial year.	✔
Directorate research activity	The number of studies within each of the directorates - included in the graph is Trustwide where the study spans directorates. The Trust has no specific target set for research activity within each directorate. It is envisaged that each clinical directorate would have a balanced portfolio.		The directorate research teams are subject to studies that are available to open. The 'type of study', Commercial, Interventional, Observational, Large scale, Patient Identification Centre (PIC) or N/A influence the activity based funding received by HDFT. Each category is weighted dependant on input of staff involvement. N/A studies are those studies which are not on the NIHR portfolio. They include commercial, interventional, observational, large scale, PIC, local and student projects. They do not influence the recruitment target.	✔

Data Quality - Exception Report




Report section	Indicator	Data quality rating	Further information
Quality	Mandatory training rates - Darlington, Durham & Middlesbrough staff	Amber 	This indicator includes training data for TUPE staff that transferred into the organisation on 1st April 2016 from Middlesbrough, Durham and Darlington. There are some concerns about the quality and completeness of this information.
Operational Performance	GP Out of Hours - National Quality Requirement 9	Amber 	Following patient pathway changes in late 2015, reports from the Adastra system no longer calculate the correct start time for these patients and as a result, the performance reported for NQR9 was incorrect. Significant work from has been carried out by information staff at HDFT and we are now able to report performance again for this metric again, based on calculations from raw data extracts from the Adastra system. The new calculations have been shared with HARD CCG.
Operational Performance	GP Out of Hours - National Quality Requirement 12	Amber 	
Quality	Reducing readmissions in older people	Amber 	This indicator is under development. We have recently amended the calculation of this indicator so that it correctly handles patients who had multiple admissions and multiple contacts with community services.
Finance and efficiency	Theatre utilisation	Amber 	The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of cancelled sessions.
Operational Performance	Children's Services - 10-14 day new birth visit	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Operational Performance	Children's Services - 2.5 year review	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Quality	Electronic rostering timeliness	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Quality	Electronic rostering hours owed	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.

Indicator traffic light criteria

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Quality	Safety thermometer - harm free care	% harm free	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%.
Quality	Pressure ulcers - hospital acquired	No. category 3 and category 4 avoidable hospital acquired pressure ulcers	tbc	tbc
Quality	Pressure ulcers - community acquired	No. category 3 and category 4 community acquired pressure ulcers	tbc	tbc
Quality	Falls	IP falls per 1,000 bed days	Blue if YTD position is a reduction of >=50% of HDFT average for 2015/16, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2015/16, Amber if YTD position is a reduction of up to 20% of HDFT average for 2015/16, Red if YTD position is on or above HDFT average for 2015/16.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	Falls causing harm	IP falls causing moderate harm, severe harm or death, per 1,000 bed days	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, NHS Improvement and contractual requirement
Quality	Infection control	No. hospital acquired C.diff cases	tbc	tbc
Quality	Avoidable admissions	The number of avoidable emergency admissions to HDFT as per the national definition.	tbc	tbc
Quality	Reducing readmissions in older people	The proportion of older people 65+ who were still at home 91 days after discharge from hospital into rehabilitation or reablement services.	tbc	tbc
Quality	Mortality - HSMR	Hospital Standardised Mortality Ratio (HSMR)	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
Quality	Mortality - SHMI	Summary Hospital Mortality Index (SHMI)	Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2015/16, Amber if on or above HDFT average for 2015/16, Red if above UCL. In addition, Red if a new red rated complaint received in latest month.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	Complaints	No. complaints, split by criteria	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
Quality	Incidents - all	Incidents split by grade (hosp and community)	Green if less than 8 SIRIs reported per month in the year to date and no never events reported in the current month; Amber if 8 or 9 SIRIs and reported per month in the year to date and no never events reported in the current month; Red if 1 or more never event reported in the current month and/or 10 or more SIRIs reported per month in the year to date.	
Quality	Incidents - SIRIs (comprehensive and concise) and never events	The cumulative number of SIRIs (comprehensive and concise) and the number of never events reported in the year to date. The indicator includes hospital and community data.		
Quality	Friends & Family Test (FFT) - Staff	% staff who would recommend HDFT as a place to work	Blue if latest month score places HDFT in the top 10% of acute trusts nationally and/or the % staff recommending the Trust is above 95%, Green if in top 25% of acute trusts nationally, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Quality	Friends & Family Test (FFT) - Staff	% staff who would recommend HDFT as a place to receive care		
Quality	Friends & Family Test (FFT) - Patients	% recommend, % not recommend - combined score for all services currently doing patient FFT	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
Quality	Safer staffing levels	RN and CSW - day and night overall fill rates at trust level	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
Quality	Staff appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months	Annual rolling total - 90% green, Amber between 70% and 90%, red<70%.	Locally agreed target level based on historic local and NHS performance
Quality	Mandatory training rate	Latest position on the % staff trained for each mandatory training requirement	Blue if latest month >=95%; Green if latest month 75%-95% overall, amber if between 50% and 75%, red if below 50%.	Locally agreed target level - no national comparative information available until February 2016
Quality	Staff sickness rate	Staff sickness rate	Green if <3.9% , amber if between 3.9% and regional average, Red if > regional average.	HDFT Employment Policy requirement. Rates compared at a regional level also
Quality	Temporary staffing expenditure - medical/nursing/other	Expenditure per month on staff types.	tbc	tbc
Quality	Staff turnover	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
Quality	Maternity - Caesarean section rate	Caesarean section rate as a % of all deliveries	Green if <25% of deliveries, amber if between 25% and 30%, red if above 30%.	tbc
Quality	Maternity - Rate of third and fourth degree tears	No. third or fourth degree tears as a % of all deliveries.	Green if <3% of deliveries, amber if between 3% and 6%, red if above 6%.	tbc
Quality	Maternity - Unexpected term admissions to SCBU	Admissions to SCBU for babies born at 37 weeks gestation or over.	tbc	tbc
Finance and efficiency	Readmissions	No. emergency readmissions (following elective or non-elective admission) within 30 days.	Blue if latest month rate < LCL, Green if latest month rate < HDFT average for 2015/16, Amber if latest month rate > HDFT average for 2015/16 but below UCL, red if latest month rate > UCL.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Finance and efficiency	Readmissions - standardised	Standardised emergency readmission rate within 30 days from HED	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
Finance and efficiency	Length of stay - elective	Average LOS for elective patients	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Finance and efficiency	Length of stay - non-elective	Average LOS for non-elective patients		

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Finance and efficiency	Non-elective bed days for patients aged 18+	Non-elective bed days at HDFT for HARD CCG patients aged 18+, per 100,000 population	Green if latest month < 2016/17 trajectory, amber if latest month below 2015/16 level plus 0.5% demographic growth but above 2016/17 trajectory, red if above 2015/16 level plus 0.5% demographic growth.	A 2016/17 trajectory has been added this month - this is based on allowing for demographic growth and reducing by the non-elective reductions identified in the Value Proposition.
Finance and efficiency	Theatre utilisation	% of theatre time utilised for elective operating sessions	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.
Finance and efficiency	Delayed transfers of care	% acute beds occupied by patients whose transfer is delayed - snapshot on last Thursday of the month.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement
Finance and efficiency	Outpatient DNA rate	% first OP appointments DNA'd		
Finance and efficiency	Outpatient new to follow up ratio	No. follow up appointments per new appointment.	Blue if latest month score places HDFT in the top 10% of acute trusts nationally. Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Finance and efficiency	Day case rate	% elective admissions that are day case	Green if on plan, amber <1% behind plan, red >1% behind plan	Locally agreed targets.
Finance and efficiency	Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s)	Green if on plan, amber <10% behind plan, red >10% behind plan	Locally agreed targets.
Finance and efficiency	Cash balance	Monthly cash balance (£'000s)	Green if rating =4 or 3 and in line with our planned rating, amber if rating = 3, 2 or 1 and not in line with our planned rating.	as defined by NHS Improvement
Finance and efficiency	NHS Improvement Financial Performance Assessment	An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.	Green if achieving stretch CIP target, amber if achieving standard CIP target, red if not achieving standard CIP target.	Locally agreed targets.
Finance and efficiency	CIP achievement	Cost Improvement Programme performance	Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan	Locally agreed targets.
Finance and efficiency	Capital spend	Cumulative capital expenditure	Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill.	Locally agreed targets.
Finance and efficiency	Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis (£'s).	to be agreed	
Finance and efficiency	Research - invoiced research activity	Trust performance on Monitor's risk assessment framework.	As per defined governance rating	as defined by NHS Improvement
Operational Performance	NHS Improvement governance rating	Trust performance on Monitor's risk assessment framework.	As per defined governance rating	as defined by NHS Improvement
Operational Performance	RTT Incomplete pathways performance	% incomplete pathways within 18 weeks	Green if latest month >=92%, Red if latest month <92%	NHS England
Operational Performance	A&E 4 hour standard	% patients spending 4 hours or less in A&E.	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	NHS England, NHS Improvement and contractual requirement of 95% and a locally agreed stretch target of 97%.
Operational Performance	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	% urgent GP referrals for suspected cancer seen within 14 days.	Green if latest month >=93%, Red if latest month <93%	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	% GP referrals for breast symptomatic patients seen within 14 days.	Green if latest month >=93%, Red if latest month <93%	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	% cancer patients starting first treatment within 31 days of diagnosis	Green if latest month >=96%, Red if latest month <96%	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 31 day wait for second or subsequent treatment: Surgery	% cancer patients starting subsequent surgical treatment within 31 days	Green if latest month >=94%, Red if latest month <94%	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	% cancer patients starting subsequent anti-cancer drug treatment within 31 days	Green if latest month >=96%, Red if latest month <96%	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	% cancer patients starting first treatment within 62 days of urgent GP referral	Green if latest month >=85%, Red if latest month <85%	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from consultant screening service referral	% cancer patients starting first treatment within 62 days of referral from a consultant screening service	Green if latest month >=90%, Red if latest month <90%	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from consultant upgrade	% cancer patients starting first treatment within 62 days of consultant upgrade	Green if latest month >=85%, Red if latest month <85%	NHS England, NHS Improvement and contractual requirement
Operational Performance	GP OOH - NQR 9	% telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation	Green if latest month >=95%, Red if latest month <95%	Contractual requirement
Operational Performance	GP OOH - NQR 12	% face to face consultations started for urgent cases within 2 hours	Green if latest month >=95%, Red if latest month <95%	Contractual requirement
Operational Performance	Children's Services - 10-14 day new birth visit	% new born visit within 14 days of birth	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
Operational Performance	Children's Services - 2.5 year review	% children who had a 2 and a half year review	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
Operational Performance	Community equipment - deliveries within 7 days	% standard items delivered within 7 days	Green if latest month >=95%, Red if latest month <95%	Contractual requirement
Operational Performance	CQUIN - dementia screening	% emergency admissions aged 75+ who are screened for dementia within 72 hours of admission	Green if latest month >=90%, Red if latest month <90%	CQUIN contractual requirement
Operational Performance	Recruitment to NIHR adopted research studies	No. patients recruited to trials	Green if above or on target, red if below target.	
Operational Performance	Directorate research activity	The number of studies within each of the directorates	to be agreed	

Data quality assessment

Green		No known issues of data quality - High confidence in data
Amber		On-going minor data quality issue identified - improvements being made/ no major quality issues
Red		New data quality issue/on-going major data quality issue with no improvement as yet/ data confidence low/ figures not reportable

Report to the Trust Board of Directors: 26 October 2016	Paper No: 8.0
Title	Finance Director's Report
Sponsoring Director	Mr J Coulter, Deputy Chief Executive/Finance Director
Author(s)	Mr J Coulter, Deputy Chief Executive/Finance Director
Report Purpose	To provide an update of the Trust's financial position
Key Issues for Board Focus:	
<p>The Board of Directors are asked to:</p> <ul style="list-style-type: none"> Note the Trust's achievement of the Quarter 2 financial plan Note that the second quarter of Sustainability and Transformation (S&T) funding will be received, totalling £1.15m Acknowledge the improvements made in relation to ward expenditure and agency spend in month Approve the submission of the Financial Sustainability Risk Rating under the Risk Assessment Framework as 4 for Quarter 2 (the equivalent rating under the new Single Oversight Framework is 1) 	
Related Trust Objectives	
To deliver high quality care	Yes – the report provides assurance that high quality care is not compromised by the Trust's financial performance.
To work with partners to deliver integrated care	Yes – the report provides assurance that it continues to work with partners to understand the financial challenges across the sector, and that the Trust continues to address the challenges within the system which may impact on the Trust's performance
To ensure clinical and financial sustainability	Yes – the report provides the Board with a detailed update on the Trust's financial performance and actions taken to ensure ongoing financial sustainability.
Risk and Assurance	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 9: risk of a failure to deliver the operating plan; BAF 10: risk of a breach of the terms of the NHS Provider Licence; BAF 12: risk of external funding constraints; BAF 14: risk to delivery of integrated models of care; and BAF 15: risk of misalignment of commissioner/partner strategic plans.
Legal/regulatory implications	The report does not highlight any legal/regulatory implications for the period.
Action Required by the Board of Directors	
<p>The Board of Directors are asked to receive and note the content of the report and approve the submission of the Financial Sustainability Risk Rating under the Risk Assessment Framework as 4 for Quarter 2 (the equivalent rating under the new Single Oversight Framework is 1).</p>	

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September 2016 Financial Position

Financial Performance

- The Trust reported a surplus of £2,927k for the year to the end of September, £38k ahead of plan. This position includes S&T funding and is outlined below:

Operating income	£105,817k
Operating expenditure	£101,509k
EBITDA	£4308k
Non operating expenses	£3,682k
Net surplus	£627k
S&T funding	£2,300k
Trust financial position	£2,927k

- There is an underlying adverse income variance of £1,699k to date. This is a £43k improvement on the year to date to the end of August. Recovery plans have had an impact in September, with the month being the highest level of acute income of the year to date, however some recovery schemes are yet to fully progress. This work needs to continue across Directorates.
- Pay expenditure is favourable with an underspend of £1,407k year to date. Encouragingly, the overspend on ward nursing reduced from £113k in August to £26k in September due to actions taken during the month.
- CIP delivery remains on track, with 97% of schemes (risk adjusted) in place and over £7.7m actioned out of our total plan of £9.4m.
- As a result of the positive performance (financially and performance standards achievement), the Trust will be eligible for the second tranche of S&T funding of £1.15m. We will be releasing £150k to Directorates for additional capital purchases as a result of this excellent performance.
- The cash position as at the end of September is marginally ahead of the revised plan, with a balance of £5.28m.
- Based upon the recovery actions underway and planned by the Directorates over the next six months, we are forecasting that we will achieve our financial plan this year. Following a review of Q2 further detail is being prepared this week which will be circulated to Board members in advance of the Board meeting.

September 2016 Financial Position

NHSI Financial Sustainability Risk Rating (FSRR)

- The table to the right outlines the Trusts FSRR for September.
- Performance in September has resulted in a FSRR of 4.

September – 16	Plan	Actual
Capital Service Capacity rating	4	4
Liquidity rating	4	4
I&E Margin rating	4	4
I&E Margin Variance rating	3	4
Financial Sustainability Risk Rating	4	4

- Given the revised monthly submission timetable for financial information to NHSI, the financial returns were submitted on 17th October. The Board is therefore asked to confirm and approve the financial return and associated risk rating that was submitted.

Single Oversight Framework

- Following consultation in July/August, NHS Improvement have introduced the single oversight framework as their approach to overseeing and supporting NHS trusts and foundation trusts.
- The framework applies from 1 October 2016, replacing the Monitor 'Risk Assessment Framework'.

The finance and use of resources score

- The financial metrics to assess financial performance of the Trust are outlined in the table below. Providers will be scored 1 (best) to 4 against each metric. These scores are then averaged to derive a use of resources score. Where providers have a score of 4 or 3 in any of the elements below, this will identify a potential support need under this theme. The performance at the end of Q2 had this assessment been in place is shown below:

September 2016	Actual
Capital service capacity	1
Liquidity (days)	1
I&E margin	1
Distance from financial plan	1
Agency spend	1
Overall Risk Rating	1

September 2016 Financial Position

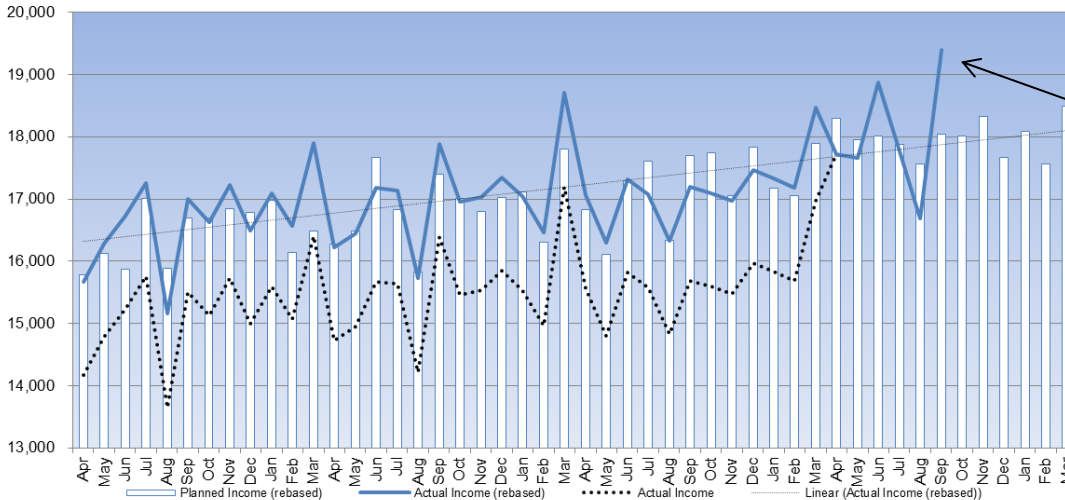
	Budget		Actual To Date £000	Cumulative Variance £000	Change in Variance £'000	September Actuals £'000
	Annual Budget £000	Proportion To Date £000				
INCOME						
NHS Clinical Income (Commissioners)						
NHS Clinical Income - Acute	142,550	70,665	69,848	(818)	379	12,394
NHS Clinical Income - Community	56,682	28,339	27,804	(535)	(290)	4,421
System Resilience & Better Care Funding	561	281	280	(0)	(0)	47
Non NHS Clinical Income					0	
Private Patient & Amenity Bed Income	1,906	968	636	(333)	(59)	99
Other Non-Protected Clinical Income (RTA)	523	261	238	(23)	(27)	17
Other Income					0	
Non Clinical Income	12,988	6,861	6,879	18	40	1,235
Hosted Services	367	141	133	(8)	(0)	35
TOTAL INCOME	215,577	107,516	105,817	(1,699)	43	18,248
EXPENSES						
Pay						
Pay Expenditure	(148,549)	(76,357)	(74,950)	1,407	453	(12,242)
Non Pay					0	
Drugs	(8,522)	(6,976)	(6,973)	3	(15)	(1,301)
Clinical Services & Supplies	(17,228)	(9,132)	(9,073)	60	97	(1,434)
Other Costs	(18,343)	(9,209)	(10,014)	(805)	264	(1,487)
					0	
					0	
Reserves : Pay	(774)	(2)	0	2	1	0
Pay savings targets	0	0	0	0	0	0
Other Reserves	(6,696)	(887)	0	887	(227)	0
High Cost Drugs	(4,233)	0	0	0	0	0
Non Pay savings targets	(169)	0	0	0	0	0
Other Finance Costs	(18)	(9)	(8)	1	1	0
Hosted Services	(1,068)	(466)	(491)	(25)	4	(92)
TOTAL COSTS	(205,600)	(103,039)	(101,509)	1,530	579	(16,556)
EBITDA	9,976	4,477	4,308	(169)	622	1,692
Profit / (Loss) on disposal of assets	0	0	0	0	0	0
Depreciation	(5,081)	(2,540)	(2,286)	254	226	(198)
Interest Payable	(90)	(45)	(100)	(55)	(9)	(17)
Interest Receivable	41	20	10	(10)	(2)	1
Dividend Payable	(2,646)	(1,323)	(1,400)	(77)	(15)	(235)
Net Surplus/(Deficit) before donations and impairment	2,200	589	533	(57)	822	1,244
Donated Asset Income	0	0	94	94	(4)	(4)
Impairments re Donated assets	0	0	0	0	0	0
Impairments re PCT assets	0	0	0	0	0	0
Net Surplus/(Deficit)	2,200	589	627	38	819	1,241
Consolidation of Charitable Fund Accounts	0	0	0	0	0	0
Sustainability and Transformation Fund	4,600	2,300	2,300	0	767	1,150
Total and Consolidated Net Surplus/(Deficit)	6,800	2,889	2,927	38	1,586	2,391
Technical Adjustments at Month 3					0	0
Sustainability and Transformation Fund					0	0
Operational Budgetary Position	6,800	2,889	2,927	38	1,586	2,391

September 2016 Financial Position

Opening Budget £000		Annual Budget £000	Workforce			In Month			Cumulative		Variance (o.s)/u.s £000
			Budget wte	Contracted wte	Actual wte	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	
1,274	Non-Commissioner Income	2,100				254	250	(4)	1,339	1,335	(4)
(34,989)	Pay	(36,374)	976.86	935.21	897.55	(3,104)	(3,001)	103	(18,670)	(17,949)	721
(2,947)	Non-Pay	(5,305)				(509)	(470)	39	(2,810)	(3,076)	(266)
(36,662)	Total Childrens & County Wide Community Care D	(39,579)	976.86	935.21	897.55	(3,359)	(3,221)	138	(20,141)	(19,690)	451
1,764	Non-Commissioner Income	3,195				260	226	(35)	1,617	1,505	(111)
(28,642)	Pay	(49,053)	1115.69	1067.49	1051.50	(4,147)	(4,219)	(72)	(25,310)	(25,393)	(83)
(7,202)	Non-Pay	(9,223)				(1,191)	(1,200)	(10)	(6,222)	(6,782)	(560)
(34,080)	Total Long Term & Unscheduled Care Directorate	(55,081)	1115.69	1067.49	1051.50	(5,077)	(5,193)	(116)	(29,915)	(30,670)	(755)
1,457	Non-Commissioner Income	1,691				143	118	(25)	798	595	(202)
(40,216)	Pay	(43,425)	905.73	860.38	827.76	(3,765)	(3,733)	32	(22,545)	(22,341)	205
(9,307)	Non-Pay	(16,019)				(1,677)	(1,658)	19	(9,695)	(9,680)	15
(48,066)	Total Planned & Surgical Care Directorate	(57,754)	905.73	860.38	827.76	(5,299)	(5,273)	26	(31,442)	(31,425)	17
(18,471)	Corporate (Clinical)	(16,894)	474.16	428.44	446.79	(1,470)	(1,424)	46	(8,381)	(8,289)	92
(137,279)	Total Clinical Spend	(169,308)	3472.44	3291.52	3223.60	(15,205)	(15,111)	94	(89,880)	(90,074)	(194)
(7,802)	Corporate (inc. CNST)	(13,798)	166.13	161.71	157.75	(1,204)	(843)	360	(6,714)	(6,604)	110
(26,273)	Total Corporate Position	(30,692)	640.29	590.15	604.54	(2,674)	(2,267)	406	(15,096)	(14,893)	202
165,941	Commissioner Income	203,695				17,174	17,996	822	101,517	100,131	(1,386)
(19,158)	Central	(13,790)	2.91	(26.01)	(27.82)	40	353	313	(2,033)	(620)	1,413
1,702	Total before donations & impairments	6,800	3,641.48	3,427.22	3,353.53	805	2,394	1,589	2,889	2,833	(57)
0	Donations for Capital Expenditure	0					(4)	(4)	0	94	94
0	Impairments on Donated assets	0						0	0	0	0
0	Impairments on PCT assets	0						0	0	0	0
1,702	Trust reporting position	6,800	3,641.48	3,427.22	3,353.53	805	2,391	1,586	2,889	2,927	38
	Charitable funds consolidation	0					0	0	0	0	0
1,702	Total Trust reported position	6,800	3,641.48	3,427.22	3,353.53	805	2,391	1,586	2,889	2,927	38

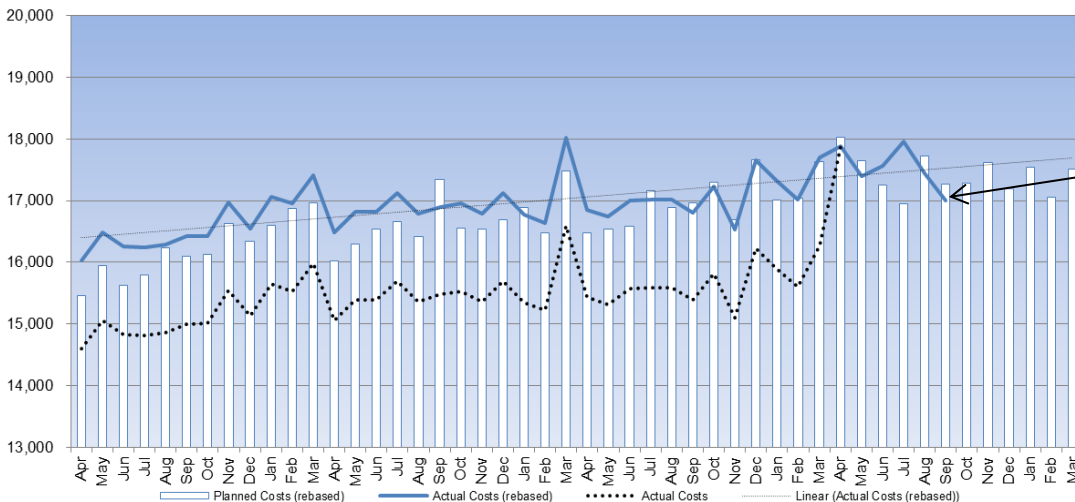
September 2016 Financial Position

Planned and Actual Income Apr 2013 - Mar 2017 (rebased for new contracts)



£19,398k income in month includes all of Q2 S&T funding (£1,150k).

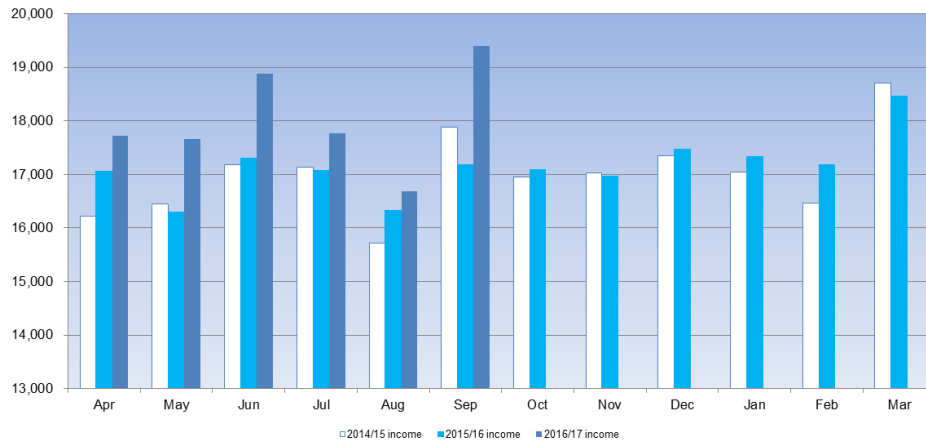
Planned and Actual Costs Apr 2013 - Mar 2017 (rebased for new contracts)



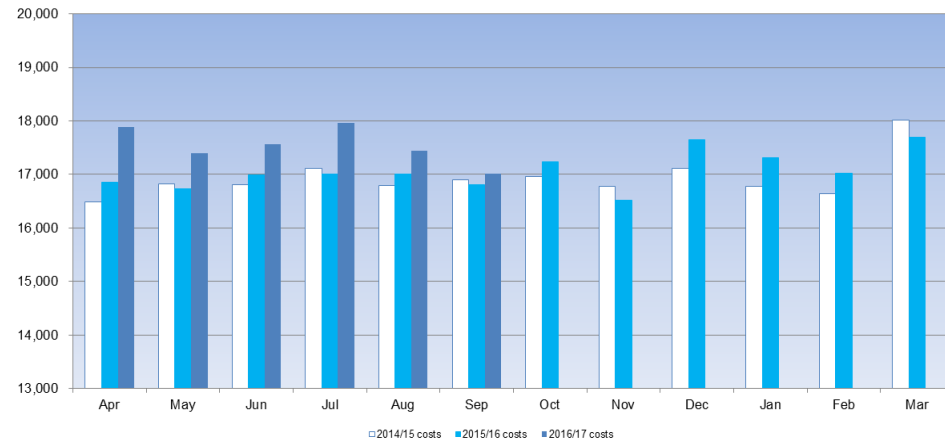
£17,007k expenditure in month.

September 2016 Financial Position

Actual Income (rebased) 2014/15, 2015/16 & 2016/17



Actual costs (rebased) 2014/15, 2015/16 & 2016/17

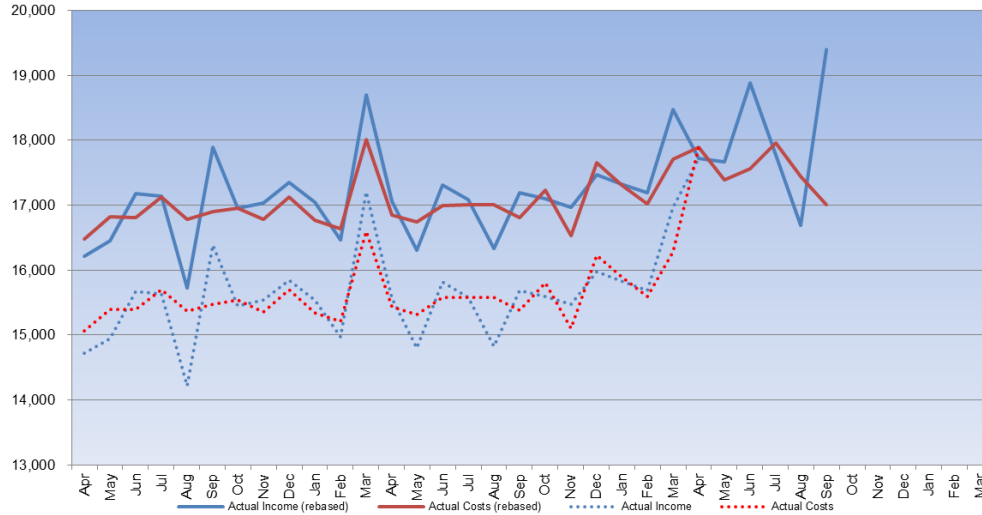


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 income plan	14,779	14,981	16,165	15,325	14,332	15,901	15,506	15,293	15,523	15,606	14,809	16,305
2014/15 income actual	14,717	14,945	15,674	15,637	14,221	16,388	15,451	15,533	15,845	15,539	14,967	17,201
2014/15 variance	-62	-36	-491	312	-111	487	-55	240	322	-67	158	896
2014/15 % variance	-0.4%	-0.2%	-3.0%	2.0%	-0.8%	3.1%	-0.4%	1.6%	2.1%	-0.4%	1.1%	5.5%
2015/16 income plan	15,335	14,610	15,799	16,105	14,830	16,202	16,245	15,554	16,329	15,677	15,560	16,385
2015/16 income actual	15,564	14,802	15,810	15,578	14,826	15,689	15,595	15,467	15,968	15,828	15,686	16,967
2015/16 variance	229	192	11	-527	-4	-513	-650	-87	-361	151	126	582
2015/16 % variance	1.5%	1.3%	0.1%	-3.3%	0.0%	-3.2%	-4.0%	-0.6%	-2.2%	1.0%	0.8%	3.6%
2016/17 income plan	18,293	17,958	18,013	17,877	17,555	18,035	18,009	18,319	17,664	18,084	17,561	18,489
2016/17 income actual	17,725	17,665	18,876	17,771	16,693	19,398						
2016/17 variance	-568	-293	863	-106	-861	1,363						
2016/17 % variance	-3.1%	-1.6%	4.8%	-0.6%	-4.9%	7.6%						

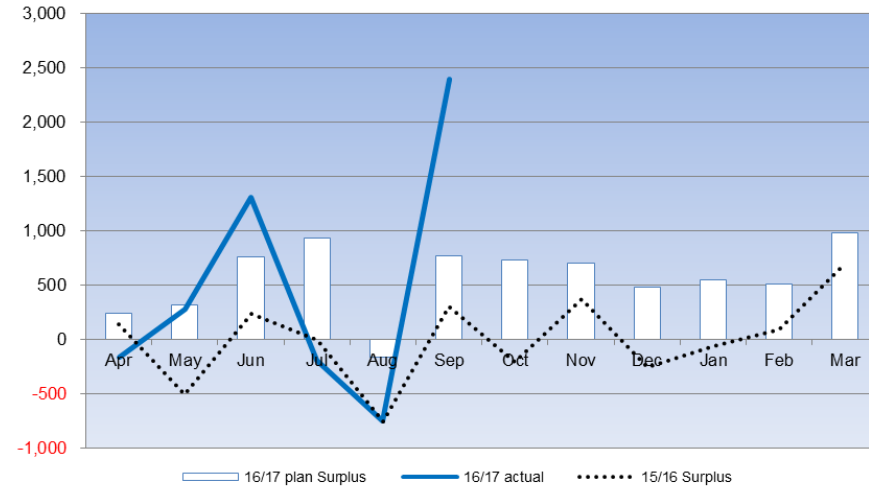
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 expenditure plan	14,602	14,875	15,107	15,236	14,983	15,912	15,128	15,105	15,268	15,465	15,052	16,051
2014/15 expenditure actual	15,058	15,394	15,387	15,695	15,362	15,476	15,533	15,358	15,695	15,346	15,214	16,591
2014/15 variance	456	519	280	459	379	-436	405	253	427	-119	162	540
2014/15 % variance	3.1%	3.5%	1.9%	3.0%	2.5%	-2.7%	2.7%	1.7%	2.8%	-0.8%	1.1%	3.4%
2015/16 expenditure plan	15,052	15,109	15,164	15,739	15,466	15,536	15,874	15,267	16,229	15,581	15,615	16,204
2015/16 expenditure actual	15,427	15,314	15,572	15,584	15,584	15,384	15,807	15,099	16,222	15,890	15,597	16,275
2015/16 variance	375	205	408	-155	118	-152	-67	-168	-7	309	-18	70
2015/16 % variance	2.5%	1.4%	2.7%	-1.0%	0.8%	-1.0%	-0.4%	-1.1%	0.0%	2.0%	-0.1%	0.4%
2016/17 expenditure plan	18,021	17,640	17,258	16,941	17,721	17,262	17,278	17,620	17,184	17,539	17,052	17,509
2016/17 expenditure actual	17,887	17,392	17,567	17,961	17,444	17,007						
2016/17 variance	-134	-248	309	1,020	-277	-255						
2016/17 % variance	-0.7%	-1.4%	1.8%	6.0%	-1.6%	-1.5%						

September 2016 Financial Position

Actual Income against Actual Cost April 2014 - March 2017



Comparison of monthly Surplus/(Deficit) - April 15 to March 17

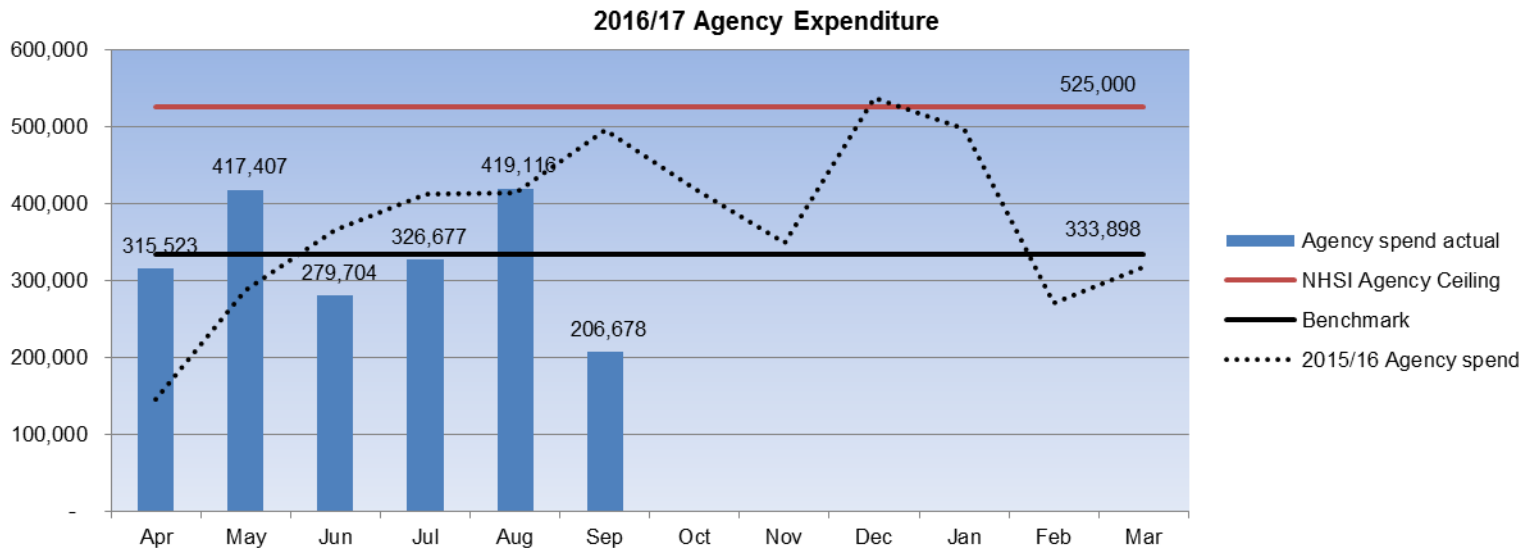


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 income	14,717	14,945	15,674	15,637	14,221	16,388	15,451	15,533	15,845	15,539	14,967	17,201
2015/16 income	15,564	14,802	15,810	15,578	14,826	15,689	15,595	15,467	15,968	15,828	15,686	16,967
2016/17 income	17,725	17,665	18,876	17,771	16,693							
2014/15 costs	15,058	15,394	15,387	15,695	15,362	15,476	15,533	15,358	15,695	15,346	15,214	16,591
2015/16 costs	15,427	15,314	15,572	15,584	15,584	15,384	15,807	15,099	16,222	15,890	15,597	16,275
2016/17 costs	17,887	17,392	17,567	17,961	17,444	17,007						
14/15 Surplus	-341	-449	287	-58	-1,141	912	-82	175	150	193	-247	610
15/16 Surplus	137	-512	238	-6	-758	305	-212	368	-254	-62	90	693
16/17 Surplus	-162	273	1,309	-190	-751	2,391						

September 2016 Financial Position

Agency Expenditure

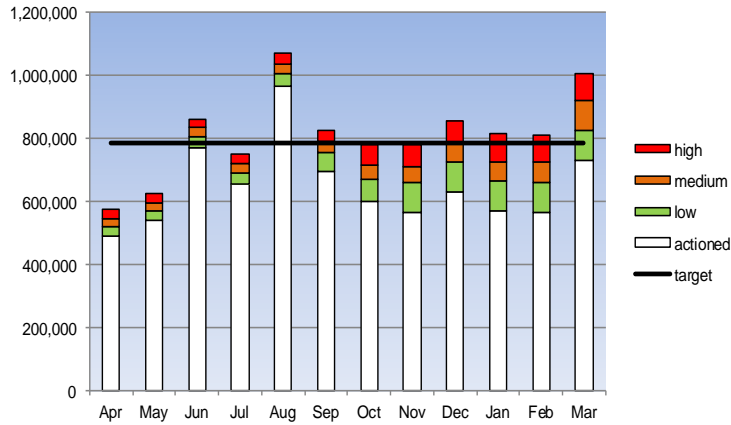
- Agency expenditure remains a key area of focus. The graph below outlines the Trust performance against the Agency ceiling. This expenditure ceiling was set by NHSI using information which included internal locum expenditure. The black line outlines a benchmark when internal locums are removed from the ceiling calculation.



2016/17 Efficiency Update

Trustwide Cost Improvement Programme

2016/17

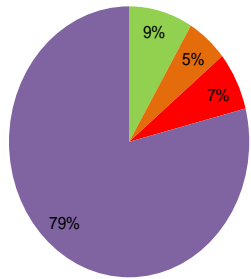


Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Trustwide	9,400,000	7,738,847	841,505	540,217	681,117	9,801,685	104%	9,106,673	97%
% age of target			9%	6%	7%				

Top 10 unactioned schemes Top 10 as % of schemes - 7%

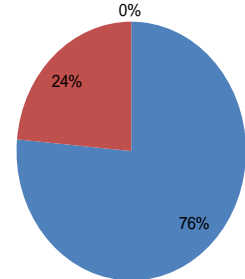
No.	Scheme	Value	Risk
1	ED Transformation	130,000	Low
2	Estates Rationalisation	90,000	high
3	Reduction in overspend on Middle Grades	75,000	Medium
4	Business Development 1	70,500	Low
5	Respiratory Outpatient review	68,400	high
6	Theatre utilisation review	60,000	Low
7	Radiology Transformation	57,000	high
8	Repatriation of hand trauma	55,000	high
9	Directorate skill mix review	54,100	Low
10	Outpatient procedure review	50,000	high

CIP schemes by Risk



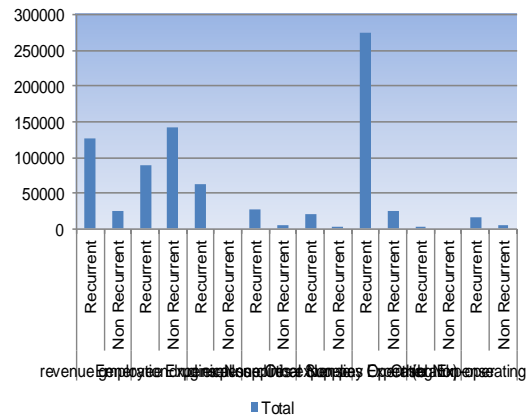
Low Medium high Actioned

Recurrent V Non Recurrent Plans

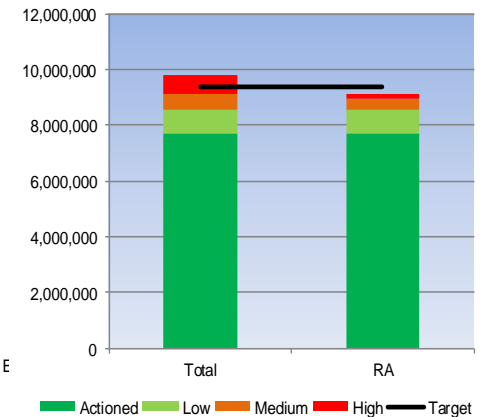


Recurrent Non Recurrent (blank)

Efficiency Category



Risk Profile



As outlined above, £7,738,847 full year effect of cost improvement schemes have been actioned to date. This equates to 82% of the target.

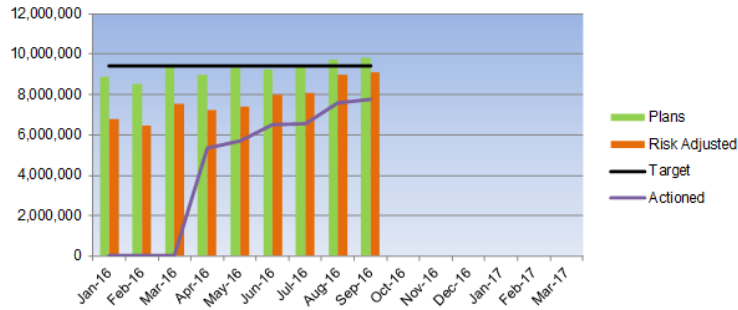
25% of plans are currently non recurrent savings. This is being reviewed as will present a risk for 2017/18.

2016/17 Efficiency Update

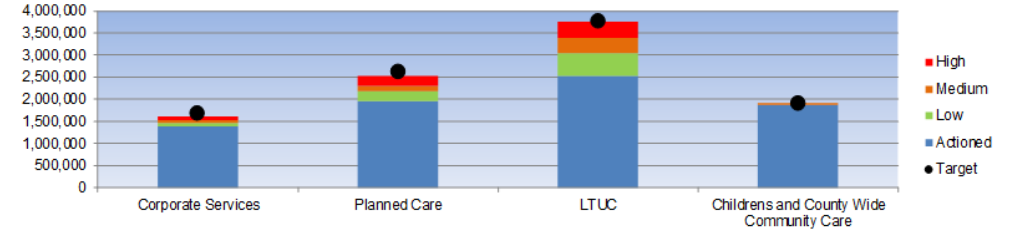
Trustwide Cost Improvement Programme

2016/17

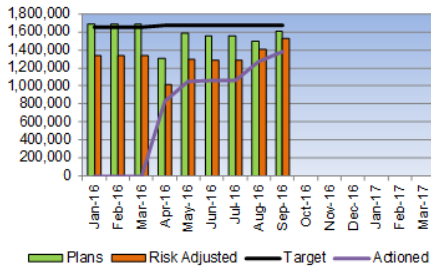
Trustwide Monthly Progress against Target (Full Year Effect)



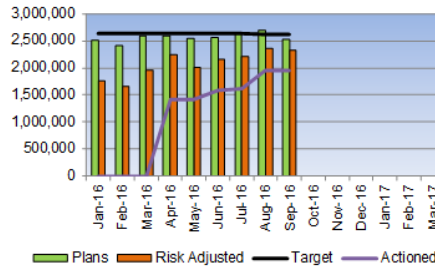
Summary	Target	Actioned	Low	Medium	High	Total	Total % age	Risk Adjust	Risk Adj % age
Corporate Services	1,675,100	1,378,200	89,300	52,000	90,000	1,609,500	96%	1,522,635	91%
Planned Care	2,620,400	1,957,147	230,625	126,917	219,717	2,534,405	97%	2,321,717	89%
LTUC	3,761,800	2,528,200	521,580	329,700	371,400	3,750,880	100%	3,361,741	89%
Childrens and County W	1,906,900	1,875,300	0	31,600	0	1,906,900	100%	1,900,580	100%



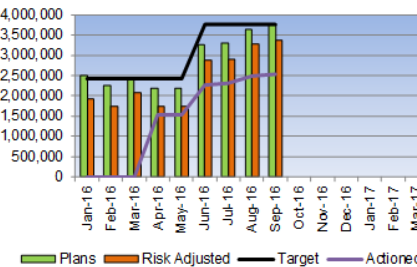
Corporate Monthly Progress against Target (Full Year Effect)



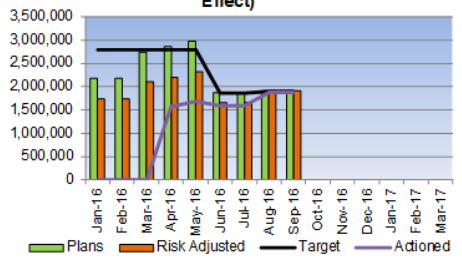
Planned Care Monthly Progress against Target (Full Year Effect)



Unplanned Care Monthly Progress against Target (Full Year Effect)



Childrens and County Wide Community Care Monthly Progress against Target (Full Year Effect)



Corporate R - NR Split



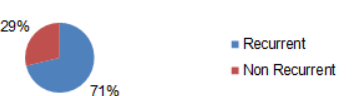
Planned Care R - NR Split



Unplanned Care R - NR Split



Childrens and County Wide Community Care R - NR Split



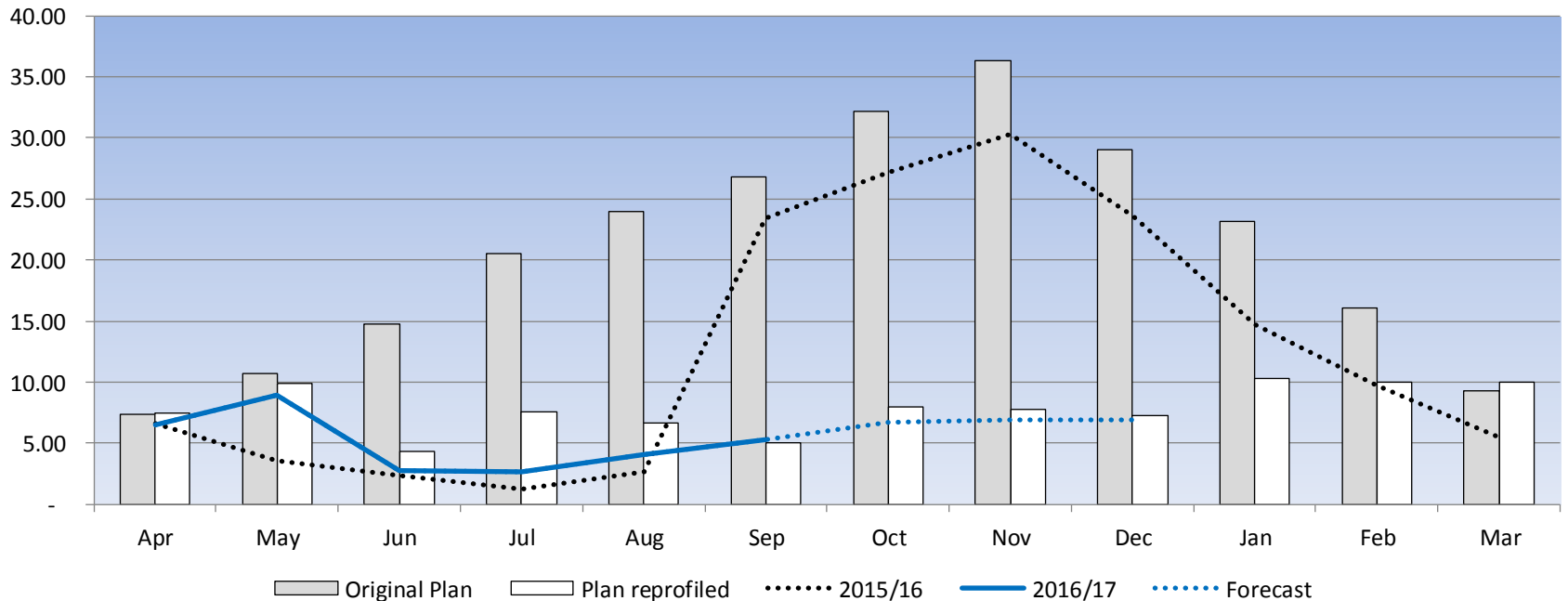
- The above highlights directorate level performance. The significant changes to planned target relate to the directorate restructure.

Cash Management

The Trust reported a cash position of £5.28m at the end of September

£'m	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	6.56	3.60	2.38	1.25	2.63	23.42	27.18	30.27	23.59	14.71	9.70	5.53
2016/17	6.54	8.89	2.77	2.61	4.04	5.28						
Original Plan	7.34	10.67	14.74	20.48	23.98	26.81	32.15	36.33	29.02	23.19	16.11	9.27
Plan reprofiled	7.48	9.86	4.33	7.57	6.66	5.06	7.98	7.75	7.27	10.27	10.02	10.01

Cashflow Monitoring 2016/17



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Report to the Trust Board of Directors: 26 October 2016	Paper No: 8.1
Title	Business Development Report
Sponsoring Director	Mr J Coulter, Deputy Chief Executive/Finance Director
Author(s)	Mr J Coulter, Deputy Chief Executive/Finance Director
Report Purpose	To provide the Board with an update on the business of the Business Development Committee
Key Issues for Board Focus:	
The Board of Directors are asked to:	
<ul style="list-style-type: none"> - Note forward planning environment, both nationally and locally. - Key actions to be taken forward in relation to both our plan and the requirement to agree contracts before Christmas. - Timeline for developing the 2 year Operational Plan - Discuss the control total proposal and approve a response to NHS Improvement 	
Related Trust Objectives	
To deliver high quality care	Yes – the Operational Plan provides the framework to ensure the continued provision of high quality services in a financially challenged environment.
To work with partners to deliver integrated care	Yes – the Operational Plan will align to the West Yorkshire Sustainability and Transformation Plan to ensure collaboration and sustainability across the system.
To ensure clinical and financial sustainability	Yes – the Operational Plan provides the platform for the Trust's approach to engaging in the wider system to ensure sustainability of services via collaboration and alliances.
Risk and Assurance	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF# 5: risk to service sustainability; BAF# 9: risk of failure to deliver the Operational Plan; and BAF# 10: risk of breaching the terms of NHS Improvement's Licence to Operate.
Legal implications/Regulatory Requirements	The report does not highlight any legal/regulatory implications for the period.
Action Required by the Board of Directors	
The Board is asked to:	
<ul style="list-style-type: none"> - Note the work that is ongoing to develop the Operational Plan for 2017/18 – 18/19 and the associated timescales - The Board of Directors is asked to discuss the control total proposal and approve a response to NHS Improvement 	

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Board of Directors 26 October 2016

Operational Plan 2017/18 – 2018/19

Report from: Jonathan Coulter Deputy Chief Executive

Report Purpose: For Information

1. Introduction

1.1 The purpose of this paper is to reflect and update on the discussions that were held at our recent Board of Directors strategy timeout. In particular, outline the:-

- Forward planning environment, both nationally and locally.
- Key actions to be taken forward in relation to both our plan and the requirement to agree contracts before Christmas.
- Timeline for developing the 2 year Operational Plan.

2. National Context and Guidance

2.1 The national guidance was issued in September 2016 which outlines the planning framework for the NHS for the next two years. The headlines are:-

- A focus on system planning
- The use of STPs as the basis for local plans and contracts
- Alignment of plans between Providers and Commissioners
- The need for transformation to deliver services within the resources available
- Focus on managing the challenging financial position of the NHS

2.2 The priorities remain as per the nine ‘must do’s’ outlined last year with the key measures being:-

- Delivery of the financial control total
- Achievement of constitutional standards in relation to RTT and A&E, and measures in relation to emergency beddays
- Emergency admissions
- Progress against the GP forward view
- Mental health forward view

2.3 In relation to efficiency, there is an emphasis on the Carter opportunities regarding procurement, pharmacy and estates, delivering rostering and job planning efficiencies, using the GIRFT metrics to drive clinical improvement, and the need to consider consolidation of pathology and back office functions.

2.4 The national guidance and priorities are not a surprise to the NHS, and as part of our STP planning and discussions both locally and across West Yorkshire, we have been considering the issues highlighted.

3. Financial Planning

3.1 The financial context remains challenging both nationally, at West Yorkshire level, and locally in Harrogate. These pressures have been articulated within our STP. In terms of assumptions to inform our financial plan the following are key factors:

- Tariff will be set at 0.1%, based upon anticipated cost pressures of 2.1% and a required efficiency of 2%
- No change in tariff rules in respect of the Marginal Rate Emergency Tariff (MRET) being set at 70% of full tariff price, with discussion with Commissioners in relation to reinvestment in services to reduce non-elective activity
- A control total for the Trust based upon delivery of a surplus of £2.4m in 2017/18 and £2.9m in 2018/19
- S&T funding being available totalling £3.8m per year for two years if we achieve our financial control total and performance standards
- CCG allocations that will be flat in real terms, and with existing financial risk within the HaRD CCG financial position for this year
- The regulatory environment in respect of the Single Oversight Framework, and the commitment we will need to make as a Board in relation to our confirmation or otherwise that we will have sufficient resources to be sustainable into the future
- The level of surplus generated to deliver a capital programme that will be required to achieve the Trust's strategic objectives
- The impact of CIP not delivered recurrently in 2016/17 that will need to be delivered again in 2017/18

3.2 In terms of process, the financial issues locally that will require to be addressed include:-

- The level of activity and associated income, bearing in mind the local Harrogate activity management plans and the plans across the STP to deliver more NHS work within the NHS.
- The principle of no new investment that does not contribute to efficiency improvements or safeguarding patient safety.
- The balance between capital and revenue and the timing of capital investments in line with CIP delivery.
- Our approach to the ward staffing cost pressure in particular, including the current bed complement and the capacity currently being increased within the Harrogate community services.
- The need to rebuild our current cash position to provide financial resilience over the planning period.
- The allocation across Directorates of the efficiency challenge.

4. Contracts

4.1. As the Board is aware, we are required to sign NHS contracts that align to STPs by 23rd December. The key contracts will be with HaRD CCG (acute and community contracts) and with the Leeds CCGs.

4.2 We have a number of contracts with local authorities, in particular for community childrens services. These contracts will continue into 2017/18 in line with existing contractual arrangements.

4.3 Negotiations with HaRD CCG have commenced and a negotiation timetable agreed. Clearly, given the nature of the financial challenges locally (which have been highlighted in our local STP) there will be particular issues to resolve in terms of the contract with HaRD CCG.

4.4 Key issues for discussion with HaRD CCG are

- Forecast outturn for 2016/17
- The roll out of the New Care Models programme and commissioning priorities
- The level of anticipated demographic pressure (as per national assumptions)
- Impact of CCG Financial Recovery Plan currently being implemented
- The scale of substitution of HaRD CCG activity with alternative work, in line with STP principles

4.5 The nature of the contract will, by necessity of the current timetable, be based upon the existing contractual mechanisms for the acute and community contracts. Further discussions in relation to alternative contractual and payment mechanisms (eg Alliance contracts) will continue, but will not be part of the next two months' contractual negotiation process.

5. Timetable and Process

5.1 The timetable for completion of the 2 year Operational Plan has been significantly shortened for this planning round, with a first draft of the plan submitted to NHS Improvement by 23 November and a final approved Operational Plan, aligned to contracts, being by 23 December 2016.

5.2 This timescale is very challenging and given the short timeframe will require significant work to be completed over the next 4 weeks to enable plans in relation to activity plans, service and capital priorities, efficiency programme and cost pressures to be identified, but recognising that further detailed work will be required following submission of the Operational Plan to provide further detail in these areas.

5.3 Business Planning meetings have already commenced and the group, including representatives from each of the Clinical and Corporate Directorates, are meeting regularly over the coming weeks.

5.4 Capacity and activity modelling is underway with first cut of the plans completed by 21 October 2016, and will be reviewed in early November 2016.

5.5 Directorates have also been requested to start identifying service capital initiatives and cost pressures, as well as developing their efficiency plans.

5.6 Whilst plans are being developed for inclusion in the plan, it must be stressed that given the short timeframe for this planning round these will need further refinement in the New Year.

6. Capital

6.1 Work is continuing to develop the Capital Estates Strategy for the hospital site. TEWW have now confirmed they will be vacating the Briary Wing by Summer 2018, and therefore detailed work has commenced regarding the future use of the accommodation. Further updates on progress will be given at subsequent Board meetings.

6.2 With regard to the capital programme, the Clinical Directorates have been requested to identify capital priorities. The following principles will be adopted:-

- Strategic capital schemes related to our business development strategy
- Separate allocations for Estates, Radiology and Theatres. Maintenance schemes and Equipment will be funded through these allocations with each of these areas.
- All other departments and any new initiatives will need to be identified and priorities agreed against available funding. It is proposed that any STP monies received will be allocated for this purpose and released on a phased basis.
- As in 2016/17 funding will only be released dependent on in year financial performance.

7. Engagement with Board of Directors and Council of Governors

7.1 The planning guidance has been released and shared with both the Board of Directors at a recent Board timeout and also with the Council of Governors through the working group held on 11 October 2016.

7.2 A draft of the plan will be presented to the Board of Directors and Governor working group for information, with the final plan submitted to the December Board for sign off. It will also be discussed at the December Finance Committee.

7.3 It should be noted that detailed budgets that reflect the operation plan will be prepared as usual for final approval at the Board in March.

7.3 A timeline for agreeing the 2017/18 – 18/19 plan is detailed at Appendix A.

8.0 Control Total

The Trust received communication from NHSI on 30th September proposing a control total for the Trust for 2017/18 and 2018/19. Acceptance of the control total would, alongside delivering the relevant performance standards, allow the Trust to access £3.8m of S&T funding in each year. The surplus we would be required to deliver is £2.4m in 2017/18 and £2.9m in 2018/19 in order to access the S&T funding. Appendix B attached to the report summarises the offer made to the Trust.

The Board is required to confirm acceptance or otherwise of the control total proposal. The Board is therefore asked to discuss the proposal and agree the approach to be taken.

9. Conclusion

9.1 The Board of Directors is asked to:-

- Note the work that is ongoing with the development of the Operational Plan for 2017/18 – 18/19 and the associated timescales.
- The Board of Directors is asked to discuss the control total proposal and agree a response to NHSI

JC/AG
14/10/16

Operational Plan 2017/18 – 18/19

Timetable

Key dates

STP submission	21.10.16
Full draft operational plan to NHS Improvement	24.11.16
Confirm acceptance of control totals	24.11.16
(Decision to enter contract mediation)	05.12.16
Board of Directors sign off Final Operational Plan	21.12.16
SIGN CONTRACT	23.12.16
FINAL OPERATIONAL PLAN TO NHS IMPROVEMENT	23.12.16
Contract signature or arbitration papers	09.01.17
(Contract signed if used arbitration)	31.01.17
Approval of Operational Budgets and Capital Programme	31.03.17

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Individual Provider Details

Harrogate And District NHS Foundation Trust (RCD)

In the tables below we set out your organisation's indicative allocations of STF, financial control totals and agency ceilings for 2017/18 and 2018/19.

2017/18 S&T funding and 2017/18 control total (£m)	
General element – S&T Fund Subject to provider eligibility and conditions	3.777
Targeted element – S&T Fund Subject to provider eligibility and conditions	To be confirmed in year
2017/18 control total (including general element of S&T Fund)	6.206 surplus

2017/18 Agency ceiling total (£m)	
2017/18 Agency ceiling total	5.591

2018/19 S&T funding and 2018/19 control total (£m)	
General element – S&T Fund Subject to provider eligibility and conditions	3.777
Targeted element – S&T Fund Subject to provider eligibility and conditions	To be confirmed in year
2018/19 control total (including general element of S&T Fund)	6.777 surplus

2018/19 Agency ceiling total (£m)	
2018/19 Agency ceiling total	5.591

Appendix 1

Control totals have been calculated on the basis of a revised, consistent financial management metric that aligns NHS Trust and NHS Foundation Trust reporting. Please see section 4.1 of 'The Sustainability and Transformation Fund and financial control totals for 2017/18 and 2018/19: guidance' for details of the adjusting items.

Control totals also include the relative price impact from the introduction of HRG4+. As described above control totals exclude changes associated with CNST income and costs. To ensure a financially neutral impact across the provider sector, gains and losses on CNST income changes compared with spend will be reflected in final control totals and included in the financial planning forms released on 1 November 2016. Therefore, when reviewing the control total in this letter providers should assume the impact of CNST changes are cost neutral.

Report to the Trust Board of Directors: 26 October 2016	Paper No: 9.0
Title	Chief Operating Officers Report
Sponsoring Director	Mr R Harrison, Chief Operating Officer
Author(s)	Ms Rachel McDonald, Head of Performance & Analysis Mr Jonathan Green, Information Analyst Specialist
Report Purpose	To provide the Board with an update on operational issues during the period for information
Key Issues for Board Focus:	
<p>The Board of Directors are asked to:</p> <ul style="list-style-type: none"> - Note that the Trust is participating in the West Yorkshire Accelerator Zone initiative to ensure that providers in West Yorkshire deliver an aggregated performance on the A&E 4-hour standard of 95% for the month of March 2017. - Note that the Trust is continuing discussions with HARD CCG regarding the funding level for the Wheelchair Service and prioritising delivery of equipment based on clinical need to ensure the service remains within budget. - Note that the Winter Resilience Plan for 2016/17 has been approved by the Operational Delivery Group. 	
Related Trust Objectives	
To deliver high quality care	Yes – the report provides updates to the Board on progress with regard to work to improve the efficiency and effectiveness of high quality care deliver within the Trust. The report provides detail on operational issues and delivery against national performance standards.
To work with partners to deliver integrated care	Yes – the report provides updates on the collaborative work with partners across the region and our commissioners to improve delivery of care and treatment to patients.
To ensure clinical and financial sustainability	Yes – the report provides the Board with assurance on progress of work across the region to ensure sustainable delivery of clinical models across the system.
Risk and Assurance	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 4: risk of a lack of interoperable systems across New Care Models partners; BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence; BAF 16: risk to delivery of integrated care models.
Legal/regulatory implications	The report does not highlight any legal/regulatory implications for the period.
Action Required by the Board of Directors	
The Board of Directors are asked to receive and note the content of the report, and approve the Information Governance Toolkit baseline submission and submission of the NHS Improvement RAF Governance compliance for Quarter 2.	

CHIEF OPERATING OFFICER'S REPORT

Board of Directors' meeting 26 October 2016

1.0 WINTER RESILIENCE PLAN

The Winter Resilience Plan for 2016/17 was approved via the Operational Management Group during October. The paper describes the robust resilience arrangements that have been put in place to enable the Trust to provide the capacity to maintain quality and continue with the delivery of safe services during the expected variations in demand over the coming winter period and within the resources available. This includes information around winter escalation processes for both the acute hospital services and community services.

The plan details the inpatient bed capacity throughout the winter period and the escalation protocols by speciality for beds and associated staffing, should capacity be insufficient due to surge in demand. The full plan will be made available in the Reading Room.

2.0 LONG TERM AND UNSCHEDULED CARE DIRECTORATE

Urgent Care

For the month of September the Trust delivered an improved position on the A&E 4-hour standard with performance above 95% for both Harrogate ED and the Trust-wide position. This means that the Trust delivered the target for Quarter 2 overall.

West Yorkshire has been chosen by the Secretary of State for Health as an Accelerator Zone for Emergency Care performance. The purpose of this initiative is to ensure the providers in West Yorkshire deliver an aggregated performance of 95% for the month of March 2017 by delivering the five mandated A&E schemes as follows:

- ED Streaming
- Ambulance Response
- Increase % of calls transferred to clinical adviser through 111
- Improve Discharge process
- Patient Flow and SAFER bundle

Harrogate and District NHS Foundation Trust are part of this accelerator zone and have submitted bids, along with the other acute providers in West Yorkshire, for funding to deliver improved performance in March 2017. For Harrogate this would be linked to achieving performance levels of above 96% and includes the capital investment required to increase capacity within our Emergency Care Department. There remain a number of significant risks associated with delivering the aggregate position which have been shared with the Secretary of State, NHSE and NHSI.

Pathology

Our Pathology Services are currently having their second United Kingdom Accreditation Service assessment (UKAS) visit for Blood Sciences and Point of Care Testing. The service was recently notified that it had become the first NHS Point of Care Testing service to become accredited to the relevant ISO standard. UKAS and the Trust will be doing a joint press release to promote this achievement.

Ward Changes

In order to support staffing pressures and ensure safe services, Byland and Jervaulx wards have been temporarily merged to become a 38 bedded elderly frailty unit.

3.0 CHILDREN'S AND COUNTY WIDE COMMUNITY CARE DIRECTORATE

0-19 Children's Services

Engagement by the new directorate management with the children's 0-19 teams is going well and all the teams in Durham have been visited. The feedback regarding the transfer to HDFT was extremely positive and this was substantiated by an independent 6 month review by the Durham commissioners who visited a number of the teams recently.

Podiatry Services

The podiatry tender has been put out by Vale of York and Scarborough CCGs. A clinical and operational team have been pulled together and a first draft of a clinical model has been developed. It needs to be noted there is a reduction of approximately £120-150k on each contract and challenging timescales.

Young People with Mental Health Co-morbidities

In line with the national position, we are experiencing an increase in the number of young people with physical health concerns and mental health co-morbidities presenting to the hospital. While the focus was initially Woodlands, through discussion it is apparent that this is a systems issue within the hospital, as the pathways for these young people may include ED and adult wards (16-19 year olds). The teams are therefore working to strengthen the process and management of this group of young people through the engagement with Harrogate CAMHS.

Wheelchair Services

The clinical risks within wheelchairs continue and is currently rated a 16 on the corporate risk register. The situation remains the same where no additional revenue has been provided to address the in-built historical deficit within the service. There is a tracker which monitors all patients who have been carefully risk assessed. It is hoped that all patients on priority one (the highest clinical risk) will receive equipment in advance of the 1st November. During November, HDFT will continue to provide assessments however will provide very limited levels of urgent equipment. All the cases on the tracker have been discussed with the Director of Nursing at HARD CCG, including the 220+ cases within priority 2 and 3 which will be transitioned to the new provider.

Community Dental Services

A clear plan is being formulated to address the growing waiting list within this service, to ensure patients receive the timely care we would expect.

4.0 PLANNED AND SURGICAL CARE

The Planned and Surgical Care Directorate is working closely with Leeds supporting the transfer of patients from Leeds for a number of specialties.

The Directorate continues to focus on recovery plans with the aim of making up the financial shortfall. Improvements have been made through September and efforts continue, working closely with clinicians.

Following the agreement with HARD CCG, Jonny Hammond, General Manager is leading on the work with the CCG to enact the 6 months Health Optimisation Programme. The aim is to start this from 1st November. The CCG are finalising the pathway and are in the process of producing information that can be provided to patients and which the Trust can use, which is essential to have in place before starting.

5.0 INFORMATION GOVERNANCE PERFORMANCE SUBMISSION – OCT 2016

The Trust is required to carry out self-assessments of their compliance against the IG requirements. The purpose of the assessment is to enable organisations to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

Information Governance Toolkit	2016/17 July Baseline Submission	2016/17 October Performance Submission
1. Information Governance Management	86%	86%
2. Confidentiality and Data Protection Assurance	87%	87%
3. Information Security Assurance	73%	73%
4. Clinical Information Assurance	100%	100%
5. Secondary Uses Assurance	91%	91%
6. Corporate Information Assurance	77%	77%
Total	84%	84%

Level 0	Level 1	Level 2	Level 3	Not Relevant
0	0	21	23	1

Performance progress

There have been no changes to the score that will be submitted in October. An annual internal audit will take place in November 2016 that includes standards that have the potential to increase to a score of 3 by March 2017. Recommendations from the audit will be completed prior to the March submission.

6.0 CARBON AND ENERGY FUND

Since the previous update the principle focus has been on establishing a completion programme with Imtech to identify all the requirements for testing and proving the new engineering systems across the site in order to finalise the project completion date. A completion date of 26th January 2017 has now been agreed with Imtech and progress against plan is reviewed in detail on a weekly basis.

Over the course of the next month, the system change over from steam to medium temperature hot water will commence with each system having a 10 day proving period before the final changeovers are made. This is programmed to be completed by the end of December.

7.0 SERVICE ACTIVITY

Variances above or below 3% are as follows – At the end of September, new outpatient activity was 4.8% below plan, follow-up outpatient activity was 3.4% below plan, elective admissions were 10.6% below plan, and ED attendances were 3.8% above plan.

For Leeds North CCG, new outpatient appointments were 15.1% above plan, follow-up outpatient activity was 4.0% above plan, and elective admissions were 4.7% below plan.

Clinical Directorates have been asked to prepare activity recovery plans for any areas of under-performance.

8.0 FOR APPROVAL

The Board is asked to approve the Information Governance Toolkit Performance submission for October.

The Board is asked to approve the Quarter 2 Governance section of the Risk Assessment Framework as **Green** for submission to NHS Improvement as detailed in the Integrated Board Report.

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Report to the Trust Board of Directors: 26 October 2016	Paper No: 10.0
Title	Chief Nurse Report
Sponsoring Director	Mrs J Foster, Chief Nurse
Author(s)	Mrs J Foster, Chief Nurse
Report Purpose	To receive, note and approve the contents of the report
Key Issues for Board Focus:	
<p>The Board of Directors are asked to:</p> <ul style="list-style-type: none"> - Note the results of Director Inspection Visits and red rating for Pannal Ward and Ice Store, Knaresborough - Note the reduction in the number of complaints received by the Trust in September - Understand the steps being undertaken to maintain safe staffing levels across the Trust and receive an update on the highest areas of risk: CATT; AMU; Byland; and Jervaulx - Note the continued support to address concerns relating to staffing issues on Farndale, Littondale and Nidderdale - Note the impact of the registered nurse recruitment initiatives, and the commencement of 26 newly qualified nurses in September and October - To receive assurance that the Trust continued to provide safe and effective care to patients during the period 	
Related Trust Objectives	
To deliver high quality care	Yes – the report provides assurance that safe staffing levels are maintained throughout the Trust, and the actions taken for areas where staffing levels have not been maintained.
To work with partners to deliver integrated care	No.
To ensure clinical and financial sustainability	Yes – the report supports to Trust’s objective to ensure quality of care is not compromised due to insufficient clinical staff.
Risk and Assurance	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 1: risk of a lack of medical, nursing and clinical staff; BAF 3: risk of a failure to learn from feedback and incidents; and BAF 13: risk of insufficient focus on quality in the Trust.
Legal/regulatory implications	The report does not highlight any legal/regulatory implications for the period.
Action Required by the Board of Directors	
The Board of Directors are asked to receive and note the content of the report.	

Unannounced Directors' Inspections 2016-2017

Date	Ward/Dept.	Risk Rating	Critical Issues	Review Date	Outcome	Critical Issues
14/04/2016	Mortuary	Green				
26/04/2016	Endoscopy	Green				
06/05/2016	Day Surgery Unit (follow up visit)	Green				
12/05/2016	Acute Medical Unit	red	Lack of cannula VIP scores.	09/09/2016 Successful audit now compliant	Green	
06/06/2016	Medical Day Unit	Amber	Largely relating to the non-compliant chairs in the treatment room and waiting room.	Update Sept Treatment room chairs now replaced. Waiting room chairs remain non-compliant.		
16/06/2016	Pannal (follow up visit)	red	Further review to be undertaken (Lack of cannula VIP scores)	Remains red following re-visit failed again.	red	
24/06/2016	Harlow	red	Lack of cannula VIP scores	JF IPC re-audited Sept Harlow now compliant	Green	
14/07/2016	Whitby Dental Clinic	Green				
29/07/16	Ice Store, Knaresborough	red				
16/08/16	Dental Clinic Settle HC	Green				

There were no Directors Inspection Visits in September

Patient Safety Visits

Since the last report to Board, the following visits have taken place:

Date	Area
01/07/16	Orthopaedic Outpatients
13/07/16	Byland/ Jervaulx
02/08/16	Maternity
27/09/16	Sewing Room
27/09/16	Woodlands

Complaints Update

The number of complaints received in September is 18.

Of the 18 complaints received in **September 2016**, there are 15 Yellow and 3 Green.

We have been monitoring contacts regarding the Wheelchair Service and to date there has been 1 formal complaint and 22 concerns raised.

Total number of complaints by month for 2016/17 compared to 2015/16													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
2016/17	18	16	23	21	25	18							
2015/16	26	18	30	15	17	26	11	9	12	12	21	16	213

Nurse Recruitment

Last month I reported the nurse recruitment campaign continues to be successful in that the number of registered nurses being recruited is exceeding the number of registered nurses leaving. This has continued.

The local recruitment event held on the Trust Open day resulted in four RNs and three Student Nurses being made conditional offers.

A team went to a recruitment event in Glasgow and made a small number of offers and gained the contact details of around 30 students.

I am pleased to report 26 newly qualified nurses have commenced work in the Trust in September and October.

We have welcomed five Registered Nurses from Spain in September and October.

Actual versus Planned Nurse Staffing - Inpatient areas

The table below summarises the average fill rate on each ward during **September 2016**. The fill rate is calculated by comparing planned staffing hours and actual staffing achieved.

In addition we are required to submit information on the total number of patients that were on each ward throughout the month – this is then used to calculate the new “Care Hours per Patient Day (CHPPD)” metric. Our overall CHPPD for September is 8.30 care hours per patient per day.

	Sep-2016						
	Day		Night		Care hours per patient day (CHPPD)		
Ward name	Average fill rate - registered nurses/midwives	Average fill rate - care staff	Average fill rate - registered nurses/midwives	Average fill rate - care staff	Registered nurses/midwives	Care Support Workers	Overall
AMU	86%	110%	96%	128%	4.40	2.80	7.20
Byland	87%	126%	103%	104%	3.20	4.10	7.20
CATT	89%	106%	121%	108%	5.80	3.00	8.80
Farndale	97%	132%	102%	153%	3.20	4.30	7.40
Granby	82%	149%	102%	160%	3.50	4.00	7.50
Harlow	-	-	-	-	-	-	-
ITU/HDU	80%	-	83%	-	22.60	2.10	24.80
Jervaulx	85%	130%	100%	113%	3.30	4.70	8.00
Lascalles	94%	97%	100%	100%	4.60	4.20	8.80
Littondale	88%	128%	94%	157%	3.40	2.50	5.90
Maternity Wards	85%	91%	91%	95%	11.80	3.50	15.30
Nidderdale	94%	116%	94%	167%	3.50	2.70	6.30
Oakdale	91%	128%	93%	153%	4.40	3.60	8.00
Special Care Baby	95%	81%	100%	-	16.80	3.20	20.00

Unit							
Trinity	97%	136%	100%	176%	3.60	3.20	6.80
Wensleydale	87%	148%	102%	140%	3.10	3.00	6.10
Woodlands	74%	123%	86%	93%	11.60	4.70	16.20
Trust total	87%	123%	96%	128%	4.80	3.40	8.30

ED staffing	89%	54%	103%	60%			
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Further information to support the September data

On the medical wards Jervaulx, Byland, AMU and CATT where the Registered Nurse (RN) fill rate was less than 100% against planned; this reflects current band 5 Registered Nurse vacancies and is reflective of the local and national position in particular regarding the difficulties in recruiting Registered Nurses. The Trust is engaged in an extensive recruitment plan in response to this. Further care staff hours were required at times in these areas to provide intensive 1:1 patient support.

In addition planned staffing levels on Jervaulx and Byland remain adjusted to reflect the closure of beds in these areas in response to Registered Nurse vacancies and activity levels.

The Harlow suite has been temporarily closed throughout September due to reduced activity levels. This has enabled nursing staff from Harlow to work on Farndale ward that currently have some vacancies and sickness.

On Granby ward although the daytime RN hours were less than planned, an assessment was undertaken on a shift by shift basis to ensure that the planned staffing matched the needs of the patients. In addition further care staff hours were required at times in this area to provide intensive 1:1 patient support.

The ITU /HDU day and night staffing levels which appear as less than planned are flexed when not all beds are occupied and staff assist in other areas. National standards for RN's to patient ratios are maintained.

On Littondale the day and night time RN hours in September were less than planned due to staff vacancies.

The planned staffing levels on the Delivery Suite and Pannal ward (maternity wards) have been combined to reflect the close working relationship of these two areas and the movement of staff between the wards in response to fluctuating occupancy and activity levels. Some of the RN and care staff gaps in September were due to staff sickness; however a professional assessment was made on a shift by shift basis to ensure that nurse staffing numbers matched the activity.

In some wards the actual care staff hours show additional hours used for 1:1 care for those patients who require intensive support. In September this is reflected on the wards; Acute Medical Unit (AMU), Byland, Farndale, Granby, Jervaulx, Oakdale, Littondale, Wensleydale and Nidderdale.

The planned staffing levels on Trinity ward remain adjusted to reflect the closure of beds in these areas in response to Registered Nurse vacancies and activity levels.

For the Special Care Baby Unit (SCBU) although the daytime RN and care staff hours appear as less than planned it is important to note that the bed occupancy levels fluctuate in this area and a professional assessment was undertaken on a shift by shift basis to ensure that the planned staffing matched the needs of both babies and families.

On Wensleydale ward the daytime RN hours in September were less than planned due to staff vacancies.

The staffing complement for the children's ward, Woodlands, is designed to reflect varying levels of occupancy. Although the day and night time RN and care staff hours are less than 100% in September, the ward occupancy levels vary considerably which means that particularly in this area the number of planned and actual nurses is kept under constant review. These figures also reflect increased investment in the Woodlands RN establishment and we are currently recruiting to this.

What this means

The actual versus planned staffing information is an indication of where the gaps are and therefore the areas at increased risk to patient safety. Whilst the risk to patient safety is increased monitoring is in place to determine if this has translated in actual patient harm.

The highest areas of risk due to nurse staffing levels continue to be on the acute floor, CATT and AMU and the frail elderly floor Byland and Jervaulx. For September, eight beds have been closed on both Byland and Jervaulx. Conversations with staff at ward level continue to be about feeling under pressure. Farndale staffing continues to be a concern and is being carefully monitored as is staffing on Littondale and Nidderdale. In other wards and department areas the concerns being raised are the movement of staff to support these areas.

On balance I believe we continue to provide safe and effective care to patients. This view is supported by our metrics related to safe and effective care such as the reductions in pressure ulcers, falls and complaints.

Main Theatre Staffing

Last month theatre staff vacancy and gap levels at Band 5 were reported at 50% of total Band 5 workforce. The position has improved with vacancies and gaps now at 38%. This is a result of five RNs returning from long term sickness.

The position will continue to improve in November when two RNs currently on Maternity Leave are returning to work and one ODP has been recruited.

Other actions taken to support the current position are the recruitment of 12 individuals on 0 hours contracts, six RNs, six CSWs. There are five RNs employed via an agency, under cap, on a block contract who are working on a weekly basis. Both of these measures contribute to consistency and familiarity which is important to theatre team working.

We have recruited to four Band 6 rotational roles and over recruited to CSW roles to commence the skills building needed to develop and grow our own workforce.

Jill Foster
Chief Nurse
October 2016

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Report to the Trust Board of Directors: 26 October 2016	Paper No: 11.0
Title	Medical Director Report
Sponsoring Director	Dr D Scullion, Medical Director
Author(s)	Dr D Scullion, Medical Director
Report Purpose	To receive an update on clinical issues
Key Issues for Board Focus:	
<p>The Board of Directors are asked to:</p> <ul style="list-style-type: none"> - Note that the HSMR and SHMI remain within expected range - Note the introduction of a staged national CQUIN payment for Trust's who achieve over 75% uptake of the Flu Vaccine for frontline workers - Note receipt of correspondence from the Deanery regarding safe practice for Core trainees in the Emergency Department 	
Related Trust Objectives	
To deliver high quality care	Yes – the report provides an update on clinical issues which may impact on the delivery of high quality care
To work with partners to deliver integrated care	Yes – the report provides assurance that the Trust continues to work with partners and colleagues at a national and local level, in preparation for forthcoming changes to guidance of a clinical nature.
To ensure clinical and financial sustainability	Yes – the report provides assurance that the Trust continues to deliver clinically sustainable services.
Risk and Assurance	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 1: risk of a lack of medical, nursing and clinical staff; BAF 13: risk of insufficient focus on quality.
Legal/regulatory implications	The report does not highlight any legal/regulatory implications for the period.
Action Required by the Board of Directors	
The Board of Directors are asked to receive and note the content of the report.	

Report by the Medical Director - October 2016

1 Mortality

The latest indices from Healthcare Evaluation Data are that Hospital Standardised Mortality Ratio's has fallen to 101.34 (103.11 last month, observation period August 2015 to July 2016). The Standardised Hospital-level Mortality Indicator has risen to 95.23 (94.37 last month, observation period July 2015 to June 2016). Both indices remain within expected levels. There have been no further developments in the National Mortality Case Record Review Programme.

2 Influenza Vaccine

I (and the Chief Nurse) have received a letter from the Medical Director of NHS Improvement on this matter. Overall uptake of frontline workers remains below recommended levels, approximately 51% in 2015. It is recommended that all trusts achieve a minimum uptake of 75%. A staged national CQUIN payment (health and wellbeing) is available depending on the level of uptake. Full payment is available for >75% uptake rates. I have already communicated with my senior clinical colleagues to emphasise the importance of this important safety measure. I have asked them to act as champions within their own clinical areas in order to achieve acceptable vaccination rates.

3. Training Matters

All Medical Directors have been copied into a recent letter from the Deanery regarding safe practice for Core trainees in the Emergency Department. This follows on from similar guidance issued last year for Foundation trainees. The guidance seeks to address the balance between appropriate involvement and training in the assessment of acute cases, whilst ensuring that patients are only discharged from acute care after review by a Doctor of ST3 grade or higher. Whilst I can report that this Trust is compliant with this guidance, the receipt of this letter coupled with information received following previous Deanery visits has given impetus to additional work to support Foundation Year Doctors on duty out of hours. This work will be led primarily by Dr Kat Johnson, Clinical Director with executive level support and input.

Under current rules, alleged impropriety on the part of Health Education England (HEE) by a doctor in training cannot be pursued through the courts as HEE does not fulfil the role of "employer". To date any action has been against employing Trusts. Following the recent junior doctor contract negotiations, this anomalous relationship has been formally altered. The proposed solution is to grant third party rights for trainees to claim breach of contract directly against HEE. This change does not affect the current relationship between trainees and acute Trusts in respect of whistleblowing or other alleged breaches of contract which can still be advanced by the employment tribunal route. The Trust has been informed of the terms of this agreement and is content with them

4. Professional Regulatory Matters

I have received from the General Medical Council written guidance for doctors who offer cosmetic interventions, and a useful link to a mental capacity tool to assist clinicians in deciding what to do when doubt exists around the ability of a patient to make decisions about their care. The cosmetic guidance has been disseminated appropriately. Similarly the latter has also been uploaded to the relevant area on the intranet.

Dr David Scullion, Medical Director
20 October 2016

Report to the Trust Board of Directors: 26 October 2016	Paper No: 12.0
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Title	Workforce and Organisational Development Update	
Sponsoring Director	Mr Phillip Marshall, Director of Workforce and Organisational Development	
Author(s)	Mr Phillip Marshall, Director of Workforce and Organisational Development	
Report Purpose	To provide a summary of performance against key workforce matters	
Key Issues for Board Focus:		
<ol style="list-style-type: none"> 1. Proposed local policy in response to the Internal Audit of Fit and Proper Persons test 2. Progress with the Ocean's Blue outcome 3. Report on visit by Health Education England (Yorkshire and Humber) 4. Summary of the results of the Q2 Staff Friends and Family Test 		
Related Trust Objectives		
1. To deliver high quality care	Through the pro-active management and development of the workforce, including recruitment, retention and staff engagement.	
2. To work with partners to deliver integrated care	Working with external organisations, including NYCC, Health Education England and NHS Employers, to provide a qualified and professional workforce fit to deliver services.	
3. To ensure clinical and financial sustainability	By seeking to recruit and retain our workforce to full establishment and minimise the use of agency staff.	
Risk and Assurance	Any identified risks are included in the Directorate and Corporate Risk Registers and the Board Assurance Framework.	
Legal implications/ Regulatory Requirements	Health Education England and the Local Education and Training Board have access to the Trust's workforce data via the Electronic Staff Records system. Providing access to this data for these organisations is a mandatory requirement for the Trust.	
Action Required by the Board of Directors		
<p>The Board is recommended to approve the local policy on regular review of the Fit and Proper Persons test.</p> <p>The Board is requested to note and comment as appropriate on the update on matters specific to Workforce, Training and Education, Service Improvement and Innovation and Organisational Development.</p>		

a) Internal Audit of the Fit and Proper Persons Test

The Trust's Internal Audit service undertook an audit of the application of the Fit and Proper Persons Test and the audit opinion was of Significant Assurance. However, the proposed action against one of the recommendations requires the agreement of the Board.

One element of the application of the Test which was described as Partly Met concerns the continuing checks of the insolvency and bankruptcy registers and the register of disqualified directors. The Trust currently undertakes these checks every three years, whilst guidance from NHS Employers is that they should be undertaken every year, as part of the appraisal process. The check entails requesting preparatory information from the individual concerned and then separate enquiries with the Disclosure and Barring Service, Companies House and the callCredit organisation, before the preparation of a letter of confirmation to the member of staff. Each of these external checks is on a 'request and await response' basis.

The guidance suggests that the Board and Council of Governors reviews the checks and agrees the outcome on an annual basis. NHS Employers' guidance also states that, as a minimum, the Nomination Committee, and through it the Council of Governors, will need to satisfy itself that the relevant checks have been carried out and will want to satisfy itself that the Board has adequate assurances on the robustness of procedures. In the opinion of the auditors (whilst recognising that Fit and Proper Persons Test checks have been carried out) the Trust does not provide positive assurance currently to the Nominations Committee that checks have been completed. The audit recommendation was that the frequency of checks should be agreed formally by the Board.

It is considered that the Trust already has in place appropriate regular review processes which manage the risk that an individual subject to the Fit and Proper Persons Test will not disclose any relevant change in their circumstances. Board members and their deputies, as well as the Clinical Directors and the Company Secretary, are required to report any such change; in the case of the Board members this is executed through a monthly standing item on the Board agenda. In addition, an annual declaration is required at the start of each financial year. The full check of all registers every three years is additional to this annual declaration. This would appear to meet the requirement for an annual review, recommended in the audit, and is also strengthened by an annual declaration being completed by all those subject to the Fit and Proper Persons Test.

The initial check was undertaken on the introduction of the Fit and proper Persons Test in late 2014/early 2015 and the next planned check will be in Q3 of 2017.

It is **recommended** therefore that the Board **approves** the current frequency of the complete checks ie every three years as Trust policy on a 'comply or explain' basis and that the completion of the annual declaration is reported to the Nominations Committee and the Council of Governors.

b) Accreditation as a MINDFUL EMPLOYER®

As part of the ongoing Health and Wellbeing programme; the Trust is pleased to announce that we have signed the Charter for Employers who are Positive About

Mental Health. This underlines the commitment to improving the working lives of staff and ensuring that we do all that we can to raise awareness of mental health issues and provide the support, guidance and recognition that this subject deserves.

The Charter for Employers who are Positive about Mental Health is a voluntary agreement and is one element of the MINDFUL EMPLOYER® initiative which is aimed at increasing awareness of mental health in the workplace and supporting businesses in recruiting and retaining staff. There are six key aims detailed in the Charter (the text of which has been placed in the Reading Room) – whilst we believe that as a Trust we already achieve some of these, there is always more that we can do.

The Trust is now able to use the MINDFUL EMPLOYER® symbol on our recruitment and other communication material, which means that we are actively promoting the positive and inclusive nature of the organisation. This is more than just adding a new logo to our letterhead – we have an ongoing programme of training open to staff to ensure that we fulfil our aims to provide non-judgemental and proactive support to any staff who experience mental health issues and we continue to develop new ways to raise awareness, provide support and address any concerns.

c) Workforce Race Equality Standard

A draft of the Trust's 2016 Workforce Race Equality Standard (WRES) was presented at SMT last week for approval with a request for feedback, comments or suggestions to help inform the finalisation of an accompanying action plan, which will be discussed and approved at the November SMT meeting. Once this process is complete the WRES Benchmarking report and accompanying action plan will be uploaded onto the Trust website in November. SMT approved the intended WRES submission.

d) Theatre staffing

Focus on addressing the vacancy and recruitment challenges in theatres continues. Recent approval has been given to the block booking of agency staff in the immediate future. These bookings are all on patient safety grounds, subject to regular review and a block booking discount was negotiated with the agency concerned. The future theatre staffing strategy is in development and was recently discussed at the Planned and Surgical Care board. In order to maximise recruitment the Trust is running a social media campaign for theatres and the theatres manager recently attended careers fairs in Glasgow and at the University of Huddersfield (the lead HEI provider for training Operating Department Practitioners). The Trust is also evaluating options such as rotational schemes with the private sector and the development/commissioning of additional HDFT-sponsored ODP training with educational providers (for future supply).

e) Locum management best practice

NHS Improvement has recently published a document entitled 'Reducing reliance on medical locums: a practical guide for medical directors'. The document sets out a number of ideas and case studies as to how Trusts have managed their use of medical locums. As examples the paper proposes actions such as:

- Ensure Trusts have access to suitable management information

- Use rostering to identify over and under establishment situations and redeploy resources where necessary/possible
- Introduce locum booking approval panels (similar to a vacancy control process)
- Develop and introduce new roles

Following consideration of the document it was felt that, whilst we clearly are experiencing similar challenges in workforce supply (that is driving the majority of agency use) to other Trusts, the options set out in the paper are either already in place (such as access to management information via Comensura) or are not suitable or would be less effective in our own Trust i.e. given our scale the example of redeploying excess resource would not be practical in many cases. We have however identified that wider distribution of our existing management information to ensure maximum visibility of spend, reasons for spend and patterns in usage would be beneficial and we will begin to circulate the monthly Comensura MI report to the Executive Team, CD, OD, GMs, HR Business Partners and Finance Managers.

A further letter from NHS Improvement was received on 18 October spelling out more detailed requirements around agency staffing, including a self-checklist for Trusts, which will be put into the Reading Room. Work is continuing on completing this.

f) Pathway to Management

This blended learning programme is comprised of a series of modules that will support the competence of our line managers, team leaders and budget holders. The programme supports the gaining of knowledge of HDFT policy and processes and the development of skills to manage people, budgets, risk and governance. The programme also provides the opportunity to undertake a self-assessment against the Healthcare Leadership model, supporting the identification of development needs; optional coaching support is available via the Health Education England (Yorkshire & Humber) Leadership Academy My E-Coach service for those line managers and team leaders who feel they need additional support in transitioning into their role. This programme will be adopted as Essential Skills Training, as a one-off requirement and will be implemented on 1 November 2016. This has been approved by Director Team.

g) National Staff Survey

The 2016 NHS Staff Survey went live on Friday 30 September 2016. The questionnaire has been circulated randomly to 1250 staff via email and hard copy across the Trust. This is undertaken by our partner, Capita, and the Trust does not know who has been selected to receive a questionnaire. This is a fantastic opportunity for staff to have their say on issues that affect them in the workplace. The feedback they provide will enable the Trust to take actions to ensure that we continue to be an employer of choice.

A number of actions have been taken in response to the feedback in last year's survey. For example:

- *10% of staff said that they experienced discrimination at work in the last 12 months (which was the same as the national average of 10%)*

As a result:

- Bullying and Harassment training is now part of the new 'Pathway to Management' training, with 93% of all managers being trained in our Bullying and Harassment policy
- We have appointed a Freedom to Speak Up Guardian, Dr Sylvia Wood who took up the role in September 2016
- *The Trust scored 3.93 with regards to staff satisfaction with the quality of work and patient care they are able to deliver (which was higher than the national average 3.92)*
- We held the Celebrating Success and long-service awards at the Family Fun Day
- We developed the Quality Charter which includes bronze, silver and gold accreditation to recognise quality initiatives across the Trust

These are just a few of the developments that have been put in place as the result of detailed analysis of the feedback in the 2015 National Staff Survey.

Regular bulletin notices and posters including progress reports are being circulated around Trust sites to encourage uptake. As an incentive for completing the survey, £1 for every returned survey will be donated to the Directorate with the highest return rate to spend on staff development. Last year's response rate was 59%, and we hope to increase our rate of responses this year.

h) Ocean's Blue

The focus continues within the 20 pilot rosters to improve rostering efficiency and visibility of management information. Ocean's Blue visited our site at the end of September and spent time with all the roster managers and Matrons to remind them of the tools available. All roster managers now have a reminder sheet of what is expected and how to use the Barnacles Dashboard to the best use. The tools already in place, such as the use of redeployment reports and Sentinel reports, have been welcomed and provide useful information that can be utilised in forward planning and preventing under- or over-staffing.

The Rostering team is working with Corporate Nursing regarding the reclamation of hours owed from the period between 1 April 2015 and 1 April 2016; hours accrued since 1 April 2016 are being used as part of the roster planning and an agreed tolerance of +/- 15 hours is being carried between rosters. Any individual outside of this tolerance will be reviewed. The Chief Nurse is leading on the process and it is planned to complete this by 30 November 2016.

The principles that have been agreed for the historical time accrual are:

- Hours are reviewed with the staff individually
- There are a number of ways to reclaim these hours - working back, sacrifice annual leave, financial repayment or a combination of these
- Hours are worked back over a period of 12 months. This will be reviewed monthly to review the reduction in balances

- Any dispute or concerns will be raised initially with the Matron, or go to a review panel if required.

j) Investors in People (IIP) reaccreditation update

The Trust's IIP re-accreditation is due by 31 March 2017, and we are planning to be re-accredited on the existing 5th Generation of the IIP standard. We plan to use an external accreditation process, which is the most cost effect route to reaccreditation to take.

Further information will be provided as we progress this piece of work.

k) Quality Charter update

Making a Difference Awards

The awards recognise colleagues who have gone the extra mile, lived the Trust's values and gone on to make a real difference. They have been fully up and running since July 2016. Fifteen individual nominations have been received to date, from both colleagues and patients. The Chairman and Chief Executive have been personally presenting the awards to the successful recipients. A dedicated page has been set up on the Trust internet site which showcases photos of and stories about our Making a Difference Award winners: <http://www.hdft.nhs.uk/trust-wide/partnerships-innovation/quality-charter/making-a-difference-award/>

Team of the Month Award

This award recognises teams who have gone the extra mile, lived the Trust's values and gone on to make a difference. Whilst the number of individual Making a Difference awards per month is unlimited, the Team of the Month is a competitive process from which there will only be one winner each month. This scheme was formally launched in September 2016, when there were five team nominations received. The Chairman and Chief Executive have now selected the winning team for September and the award will be made in due course. Details of the scheme, for which any Trust team may be nominated, are available on a dedicated page which has been set up on the Trust internet site: <http://www.hdft.nhs.uk/trust-wide/partnerships-innovation/quality-charter/team-of-the-month-award/>

l) Health Education England (Yorkshire and Humber) (HEE) visit - 4 October 2016

HEE visited the Trust on 4 October 2016 to inspect the quality of training provided to Trainee Doctors at HDFT. HEE measures the Trust's performance as a training provider, using the General Medical Council's standards for training. The panel also reviewed progress on the conditions and recommendations issued following the 2015 annual visit, and the triggered visit to medicine in January 2016. Dr Simon Holbrook, Director of Medical Education, presented key points on improvements made since the last visit in January 2016.

The HEE panel, led by Dr Peter Taylor, Deputy Postgraduate Dean, met with all grades of trainees in medicine, surgery, obstetrics and gynaecology, and foundation trainees across all specialties. Where available the panel also met with relevant trainers involved in clinical and educational supervision, meeting once more with the Trust panel at the end of the afternoon to provide feedback on their findings.

The panel was very pleased with the Trust for progress on the conditions from the previous visits. In particular the Trust was removed from enhanced monitoring for Core trainees in Medicine with the GMC due to satisfactorily meeting the requirement of ensuring trainees attend the necessary number of clinics to meet their curriculum requirements.

The Trust was given 28 days to meet GMC mandate on ensuring Foundation Year 2 surgical doctors have senior resident support in the Trust. HEE was clear that the current arrangements for senior non-resident support would not be acceptable in the future. Senior clinicians from the surgical specialties attended the visit to discuss the options for meeting this requirement. A report is to be submitted to HEE by 1 November 2016 (by Dr Holbrook, on behalf of the Directorate concerned) detailing senior resident cover arrangements.

Early indications from the feedback are that trainees stated they would recommend working at Harrogate and recommend the Trust to their friends and family. The only exception to this was one Foundation Year 2 doctor.

Due to the timing of HEE visiting the Trust coinciding with rotation day for higher trainees in medicine, a smaller panel will be revisiting the Trust in the near future to meet with the new cohort, to gain further feedback on the quality of training for ST3+ in the medical specialties.

A draft report will be submitted by HEE(Y&H) for verification of accuracy, usually within the next four weeks, before being formally submitted to the Trust for circulation and published on HEE's website.

m) Doctors in Training – new contract update

Following the decision of the High Court in mid-September that the Judicial Review of the Secretary of State's competence to recommend implementation of the new Terms and Conditions for Doctors and Dentists in Training had failed, it was clear that implementation would take place in accordance with the timetable issued by NHS Employers. The Chairman of the BMA Junior Doctor's Committee wrote to the Chief Executive laying out a number of prerequisites with which the Trust would have to comply and the response was clear – the Trust expected all of them to be in place before 7 December, when the first FY1 doctors move on to the new contract. These include the development of a local Public Service Equality Duty document, which was approved by the Trust Equality and Diversity Group on 30 September, and the appointment of a Guardian of Safe Working Hours (Dr Gray was appointed on 11 July). A similar letter was received from a senior doctor in training in the Trust (now rotated out) and received a similar response.

On starting work at HDFT, the 20 FY1 doctors in training had been issued with a contract under the 2002 Terms and Conditions which expires on 6 December and they will be given one month’s notice in early November, in accordance with best practice. They have now received a contract under the new Terms and Conditions which commences on 7 December and covers the remainder of their year here (to August 2017). All FY1 doctors working on or after 7 December will be working under the new Terms and Conditions – it is not possible to ‘carry over’ any element of the 2002 contract. The FY1 doctors in training were offered the opportunity to discuss their new contracts at two engagement events on 18 and 19 October.

n) Job Planning

The latest job planning figures for Consultants and Specialty Doctor and Associate Specialist grades as at 30 September 2016 are shown in the table below. Overall progress in completed Job Plans month on month is shown as a RAG rating.

OCTOBER 2016 JOB PLANNING CENTRAL REPORT - CONSULTANTS										
Directorate	Number of Consultants	Job Plans within 12 months	%	Job Plans older than 12 months	%	Number of Consultant with no Job Plans recorded	%	In progress	Notes	RAG
C & CWCC	12	11	91.67%	0	0.00%	1	8.33%	0	One on maternity leave	
LT & UC	53	47	88.68%	6	11.32%	0	0.00%	0		
P & SC	69	60	86.96%	8	5.00%	1	1.45%	0		
Total	134	118	88.06%	14	10.45%	2	1.49%	0		

OCTOBER 2016 JOB PLANNING CENTRAL REPORT - SAS GRADES										
Directorate	Number of SAS Doctors	Job Plans within 12 months	%	Job Plans older than 12 months	%	Number of SAS Doctors with no Job Plans recorded	%	In progress	Notes	RAG
C & CWCC	6	4	66.67%	2	33.33%	0	0.00%	0	Both Sep 2015	
LT & UC	11	1	9.09%	3	27.27%	7	63.64%	0		
P & SC	41	11	35.30%	2	4.88%	28	68.29%	0		
Total	58	16	27.59%	7	12.07%	35	60.34%	0		

Change from previous month (in-date JPs)	Improved		No change		Worse					
NB Substantive new starters now included as compliant for first six months as per current Job Planning policies										

The Job Planning Working Group met on 11 October and considered a proposal to review Category A and B on-call payments to doctors. It was agreed that Clinical Leads would be invited to complete a short survey which would help to provide robust evidence justifying the previous categorisation applied to all consultant medical staff. The Group also discussed a revised Job Plan Policy to include improvements to the templates and proposals to ensure compliance, and the development of objectives by Clinical Leads, for inclusion in all Job Plans, which reflect the priorities of the Trust, the Directorate and their specialty. Focus remains on reducing the number of uncompleted job plans.

o) Appraisals

The Trust has seen a renewed focus on appraisal completion over the June-September period, with small increases in compliance rates in some areas. All areas which were under 90% compliance in July were asked to provide a plan of action in order to achieve this level by December 2016. There are meetings scheduled with Operational Directors and Management Teams for all areas with Director and Deputy Director of Workforce and OD along with the relevant HRBP to see what support and guidance may still be required to ensure that the action plans previously presented can be delivered.

The toolkit is live and managers are receiving monthly position reports. It is advised that these reports are checked monthly when issued by Workforce Information so that if there are any anomalies or data cleansing required it is done in timely manner.

p) Flu

Flu Vaccinations have commenced with the launch day on 3 October. It has been challenging to obtain details of flu drop-in sessions for our partner Trusts but we have now published a very comprehensive list of sessions available across the whole of the patch served by the Trust, including community partners, and this is now on the Intranet.

The Trust has a number of Flu champions across both the acute and community settings and we are really pleased to be partnering with the school nurses in the community, especially in the Darlington, Durham and Middlesbrough areas, to deliver the staff vaccine locally. There are a further two other weeks of dates for staff sessions scheduled and Flu Champions are available at any point. All the details are attached to the Flu Champion list on the Intranet page, along with research and clinical information for those who wish to review the clinical evidence.

Staff receive a limited edition button badge and Kitkat bar (other chocolate bars are not available!) for as long as stocks last. Those attending the lunchtime sessions on the acute site receive homemade cakes or fruit.

The target for uptake for the 2016/17 campaign is 75%.

q) Staff Friends and Family Test 2016-17 Q2

I attach the latest summary report at Annex to this paper. The response rate was above the national average for this Quarter and I am pleased to report that the HDFT scores for both questions are also significantly above the national averages.

r) Sickness Absence update

Trustwide sickness absence rates showed an increase during August to 3.99% from July's 3.8% figure. This absence level remains below the corresponding period from last year. Significant concerns remain in the accuracy and timeliness of absence reporting within the Children's and County Wide Community Care Directorate, particularly relating to the staff that recently transferred their employment to the Trust, where August saw

further adjustments to absence records for both June and July. Current figures show a three month low of 4.45% absence; previous months, however, have suggested that this is likely to be inaccurate. All other Directorates have shown increases in sickness absence rates, with Corporate Services, including both Domestic and Medical Records, recording increases.

Stress, anxiety and depression-related absence remains the leading cause of sickness throughout the organisation, although levels have reduced both proportionately and in terms of whole time equivalent lost. Current training courses - Mental Health First Aid and Mentally Healthy Workplace - are being well attended and will continue to provide opportunities to better address mental health related absences; in addition, the signing of the Mindful Employer Charter underlines our commitment in this area. "Other known causes" are now the second highest reasons for absence - as a result of this managers continue to be educated to ensure that absence is categorised in the most accurate way possible. Musculo-skeletal and back problem-related absence appear to have remained relatively constant with a slight decrease month on month. There is a clear indication that the former are disproportionately high within the nursing staff groups and that back problems appear to be higher in administrative based roles - as well as medical and scientific areas. As a result of this, awareness of warning signs and sources of support and guidance on assessments is being raised within these groups. There has been an overall decrease in the number of staff reported as being on long term sickness absence, the majority of this has been as a result of clarification of the status of staff within the Children's Services teams in the North East.

Phillip Marshall
Director of Workforce and Organisational Development

October 2016

Annex: Staff Friends and Family Test 2016-17 Q2 summary

Friends and Family Test Report: Quarter 2 2016/2017

The Staff Friends and Family Test is a feedback tool for staff, predominately to support and influence local improvement work. It allows us to take a 'temperature check' on how staff are feeling and is a complimentary engagement activity to the annual NHS Staff Survey.

The Staff Friends and Family Test include the following two questions:

1. How likely are you to recommend the Trust to friends and family if they needed care or treatment?
2. How likely are you to recommend the Trust to friends and family as a place to work?

The Trust is in receipt of a full outcome report which presents the responses from all staff who participated in the Staff Friends and Family Test. The report provides data which includes a response breakdown by the Trust as a whole and by directorates.

The Staff Friends and Family Test for Quarter 2 2016/17 was operated from 12 August 2016 to 9 September 2016 with 3,763 staff being invited to participate. There were 608 respondents which is the equivalent to a 16% response rate. Nationally, the average response rate in quarter 1 of 2016/17 was 13%.

Specific actions continue to be taken to increase participation rates in future quarterly Staff Friends and Family Test surveys. Feedback which has been received during quarter 2 is to consider sending the Staff Friends and Family Test as a paper survey as opposed to relying on online responses.

From the survey responses that were received, the lowest participation rate in Quarter 2 2016/2017 was from Planned and Surgical Care at 16% and the highest participation rate was from Long Term and Unscheduled Care at 30%. Children's and County Wide Community Care received a response rate of 27% and Corporate received 28%.

In Quarter 2, 87.3% of staff would recommend the Trust to friends and family for the standard of care provided and 70.4% recommended the Trust as a place to work.

The national average for the number of staff that would recommend the Trust to family and friends for treatment or care (Q1 2016/17 published data) is 80%. The national average for the number of staff that would recommend the Trust as a place to work is 64%. The Harrogate and District NHS Foundation Trust scores are well above the national averages for both indicators.

The national average information for the quarter 2 Staff Friends and Family Test is not yet available.

The Staff Friends and Family report for quarter 2 highlights verbatim comments on each standard question which gives staff the opportunity to comment further if they wish to do so. The opportunity to provide further comment by staff members is a crucial element to the Staff Friends and Family Test as it helps the Trust to drive improvement forward and to celebrate successes.

The table is a summary of the outcome report which indicates the overall response rates to each of the questions for each directorate. In addition to this, there are tables of information relating to common themes.

Recommend as a place for care/treatment	Extremely Likely	Likely	Neither Likely or unlikely	Unlikely	Extremely Unlikely	Don't know	Total
Corporate	100	51	8	7	2	1	169
Planned and Surgical Care	43	46	4	2	0	0	95
Long Term and Unscheduled Care	76	83	13	3	3	0	178
Children's and County Wide Community Care	65	64	26	3	2	3	163
Recommend as a place to work	Extremely Likely	Likely	Neither Likely or unlikely	Unlikely	Extremely Unlikely	Don't know	Total
Corporate	65	60	20	18	4	1	168
Planned and Surgical Care	21	44	13	12	3	0	93
Long Term and Unscheduled Care	59	60	34	14	7	0	174
Children's and County Wide Community Care	43	67	31	13	5	1	160

CORPORATE	
Recommend as a place for treatment	Recommend as place for work
Extremely Likely/Likely <ul style="list-style-type: none"> - Great place for treatment/excellent care - Very friendly - Short waiting lists/prompt appointments 	Extremely Likely/Likely <ul style="list-style-type: none"> - Supportive and friendly - Flexible - Career progression opportunities
Unlikely/Extremely Unlikely <ul style="list-style-type: none"> - Short notice appointments without reasonable notice - Waiting times in GP Out of Hours Clinic are too long 	Unlikely/Extremely Unlikely <ul style="list-style-type: none"> - Stressful working environment - Staff shortages
PLANNED AND SURGICAL CARE	
Recommend as a place for treatment	Recommend as place for work
Extremely Likely/Likely <ul style="list-style-type: none"> - Friendly/caring staff - Supportive - Good quality care 	Extremely Likely/Likely <ul style="list-style-type: none"> - Friendly/caring staff - Good place to work
Unlikely/Extremely Unlikely <ul style="list-style-type: none"> - Staffing shortages/pressures 	Unlikely/Extremely Unlikely <ul style="list-style-type: none"> - Managerial support limited - Staff shortages - Workplace pressures

CHILDREN'S AND COUNTY WIDE COMMUNITY CARE	
Recommend as a place for treatment	Recommend as place for work
Extremely Likely/Likely <ul style="list-style-type: none"> - Good quality of care - Friendly/caring staff 	Extremely Likely/Likely <ul style="list-style-type: none"> - Friendly staff/hospital - Professional - Well supported
Unlikely/Extremely Unlikely <ul style="list-style-type: none"> - Poor communication - Staff pressures 	Unlikely/Extremely Unlikely <ul style="list-style-type: none"> - Staff pressures - Support limited - Low morale
LONG TERM AND UNSCHEDULED CARE	
Recommend as a place for treatment	Recommend as place for work
Extremely Likely/Likely <ul style="list-style-type: none"> - Friendly - Caring staff - Clean 	Extremely Likely/Likely <ul style="list-style-type: none"> - Friendly staff - Supportive environment
Unlikely/Extremely Unlikely <ul style="list-style-type: none"> - Staff shortages - Low morale 	Unlikely/Extremely Unlikely <ul style="list-style-type: none"> - Staff shortages - High work pressures - Poor communication (community contract changes)

Actions plans are being developed within Directorates to take forward the survey findings.

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Report to the Board from the Quality Committee

Committee Name:	Quality Committee
Committee Chair:	Mr Neil McLean, Non-Executive Director/Quality Committee Interim Chair
Date of last meeting:	5 October 2016
Date of Board meeting for which this report is prepared	26 October 2016
Summary of live issues and matters to be raised at Board meeting:	
<p>Hot Spots</p> <ul style="list-style-type: none"> Complaint response times as evidenced by Patient Experience and Incident Report for Q1 Theatre staffing including consultant response Gastroenterology including back-log and consultant staffing <p>Nursing</p> <p>Issues relating to nurse leadership on wards, shortages, sickness and training were examined at length including the Nurse Development and Training Report. It was noted that the senior nursing team were meeting to review how issues around recording training and development could be resolved.</p> <p>Theatre staffing</p> <p>The committee noted that there was a 50% gap in the rota and the initiatives to recruit medium term agency staff and potentially staff via the Global Health Exchange was discussed. The effect on consultants, their rotas and associated issues was also considered.</p> <p>Gastroenterology</p> <p>The considerable backlog and the closure to new patient referrals was a matter of considerable concern. It was noted that the return of one consultant was expected to alleviate the position over time. Further work is needed with the consultant team to address workloads.</p> <p>Quality Priorities Reports</p> <p>The Committee received the following verbal or written reports:</p> <ul style="list-style-type: none"> <u>Improving stroke care</u> – a verbal update on good continuing progress was received. <u>Nurse Training and Development</u> – a very detailed report as referred to above was received which identified a number of issues particular relating to recording and visibility of training which the senior nursing team are to address. <u>Patient Experience and Incident Q1</u> – a detailed report was received which evidenced good progress in some areas but continuing difficulties in others. In particular there was concern over the number of complaints and a failure to meet target in addressing them with only 34% against a target of 95% in Q1. It was suggested that issues around the reorganisation of the Directorates may have contributed. In addition processes had to be improved to ensure issues were addressed early to avoid them becoming complaints. The committee will keep this under close review. <u>Friends and Family Test process</u> – it was noted that it was recommended that the current system was to be retained as fit for purpose. Efforts will be made to establish processes to engage with children and young people. <u>DNACPR</u> – communication with patients and families had improved but complete recording still required development. <u>GPOOH</u> – new indicators have been developed and data quality improved. Future reporting will be via the IBR. 	

External Reports

- National Hip Fracture Audit- HDFT is one of the best performers regionally but further improvement is required.
- Acute pancreatitis- overall compliance is good but further work is needed.
- National cancer patient experience 2015- HDFT is a leading performer nationally but work is on-going to achieve continual improvement
- National emergency laparotomy audit- only 50% of patients was seen by a consultant within 14 hours and work was on-going to address the position.

The Quality committee will monitor outcomes relating to the above going forward.

Are there any significant risks for noting by Board? (list if appropriate)

Hotspots as above

Matters for decision

None

Action Required by Board of Directors

The Board are asked to note the content of the report.

Report to the Board of Directors from the Chair of the Finance Committee

Committee Name:	Finance Committee
Committee Chair:	Mrs Maureen Taylor, Non-Executive Director/Finance Committee Chair
Date of last meeting:	19 October 2016
Date of Board meeting for which this report is prepared	26 October 2016
Summary of live issues and matters to be raised at Board meeting:	
<p>The Board is asked to note that:</p> <ul style="list-style-type: none"> • The financial position at month 6 shows a surplus of £627k, excluding S&T funding. This is above plan and as a result of this and operational performance meeting targeted levels, the Trust will now receive the full quarter 2 S&T funding. This has resulted in a total surplus of £2,927k for the Trust. • Recovery plans have had an impact with September being the highest level of acute income to date and pay expenditure continues to show a favourable variance. • CIP schemes have been actioned with a full year savings impact of £7.7m. Plans are in place for the remaining £2.1m. 25% of schemes are non-recurrent schemes and as such are a risk carried into 2017/18. • Following such a positive position for September, the Financial Sustainability Risk Rating for Q2 is 4. The new single oversight framework will be in place from 1st October. • Cash at the end of September was £5.28m, £0.22m ahead of plan. Debt collection shows improvement but GP out of hours remains a significant outstanding issue with the value of invoices standing at £1.4m. The next stage is escalation to Directors of Finance. • Discussions took place about the issues around agreeing activity levels with the HaRD CCG for the next two years and the resulting financial implications for the Trust. Work continues on this. • Activity at Alwoodley is behind plan, in the main due to the fact that the N3 connection has not been installed, preventing x-ray and ultrasound facilities from taking place. Installation is imminent and the additional capacity ready to go on 'choose and book'. • The Committee considered the assumptions supporting a business case relating to the front of house catering facility at the hospital. The business plan will be considered by the Board in October. • The Committee looked at the BAF Financial Risks and agreed that BAF 14 and BAF 15 (financial failure of a partner in the system and misalignment of commissioner/partner plans and lack of trust) were still the key financial risks. 	
Are there any significant risks for noting by Board? (list if appropriate)	
<ul style="list-style-type: none"> • Delivery of CIP and the impact on 2017/18 of the non-recurrent element; risk of timely collection of debts in relation to GP out of hours; agreeing activity levels with the HaRD CCG for the next two years. 	
Matters for decision	
None	
Action Required by Board of Directors	
The Board is asked to note the content of the report.	

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Report to the Trust Board of Directors: 26 October 2016	Paper No: 15.1
Title	Standing Financial Instructions and Standing Orders
Sponsoring Director	Mr J Coulter, Deputy Chief Executive/Finance Director
Author(s)	Mr Thomas Morrison, Head of Financial Accounting and Ms Debbie Henderson, Company Secretary
Report Purpose	To undertake the annual review of the Trust's SFIs and Standing Orders
Key Issues for Board Focus:	
Executive Summary: The Trust's Standing Financial Instructions, Delegated Limits and Standing Orders have been reviewed by the Audit Committee on 7 September. The Audit Committee approved them subject to some minor amendments and recommended onward approval by the Board.	
Related Trust Objectives	
To deliver high quality care	Yes – the SFIs and Standing Orders provide assurance that high quality care is not compromised by ensuring that responsibility and accountability is reflected within the Trusts governance framework.
To work with partners to deliver integrated care	No
To ensure clinical and financial sustainability	Yes – the SFIs and Standing Orders provides the Board with assurance of appropriate financial accountability and decision making within a robust governance framework.
Risk and Assurance	Risks associated with the content of the report are reflected in the Board Assurance Framework via BAF 10: risk of a breach of the terms of the NHS Provider Licence.
Legal/regulatory implications	The report does not highlight any legal/regulatory implications for the period.
Action Required by the Board of Directors	
The Board of Directors are asked to approve the Standing Financial Instructions and Standing Orders and acknowledge the requirement for annual review.	

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STANDING FINANCIAL INSTRUCTIONS: Delegated Limits

Version	Date	Purpose of Issue/Description of Change	Review Date
1	Mar 05	Initial Issue – author J Gibbons	Mar 06
2	Aug 05	Further amendments incorporating comments from: S Warren and A Lawson. Also reviewed in light of other FT documents.	Mar 06
3	Feb 06	Final amendments, incorporating comments from J	Feb 07
4	Aug 06	Lawlor	Aug 08
5	Mar 09	Incorporating Audit Committee amendments from June 2006 meeting.	Mar 12 Aug 10
6	Aug 10	Incorporating amendments from Internal Audit, Planning, Estates, Supplies and Finance. Interim review following organisation restructure.	Mar 12 Aug 11
7	Aug 11	Post TCS review and 36 month review of document.	Sept 14
8	Mar 12	Changes proposed by Deputy Director of Planning approved March 2012 Board of Directors meeting.	Sept 14
9	Sept 14	Periodic review.	May 16
10	Aug 16	Periodic review	Sep 19
Status		Open	
Publication Scheme		Document Library>>Policies	
FOI Classification		Release without reference to author	
Function/Activity		Standing Financial Instructions	
Record Type		Corporate documentation	
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Standard		N/A	
Scope / Location		Trust-wide	
Author		Finance	Date
Approval and/or Ratification Body		Audit Committee Board of Directors	Sept 16

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2. PROCUREMENT LIMITS (Quotes and Tenders).....	5
3. CAPITAL/BUSINESS CASE INVESTMENT LIMITS	5
4. LOSSES AND SPECIAL PAYMENTS LIMITS	6

STANDING FINANCIAL INSTRUCTIONS

1. IMPLIED SCHEME OF DELEGATION

Para	Area of Responsibility	Responsible Officer	Deputy Officer	Limits of Responsibility
3.1.1	Business Plan	Chief Executive	Deputy Chief Executive	-
3.1.2	Budgets	Finance Director	Deputy Finance Director	-
3.2.1	Budgetary Delegation	Chief Executive	Finance Director	-
3.2.2	Budget Virement	Chief Executive	Finance Director	See Detailed Financial Procedures
3.3	Budgetary Control	Finance Director	Deputy Finance Director	-
3.3.3	Cost Improvements / Income Generation	Chief Executive	Finance Director	-
3.5	NHS Improvement Returns	Chief Executive	Finance Director	Financial Returns
4	Annual Accounts	Finance Director	Deputy Finance Director	-
5.2	Bank and GBS accounts	Finance Director	Deputy Finance Director	See Treasury Management Policy
5.4	Investments	Finance Director	Deputy Finance Director	See Treasury Management Policy
5.5	Borrowing	Finance Director	Deputy Finance Director	-
6	Income, Fees and Charges	Finance Director	Deputy Finance Director	-
7	Contracting for Provision of Services	Chief Executive	Finance Director	-
8.2	Funded Establishment	Chief Executive	Finance Director	-
8.3	Staff appointments	Chief Executive	Director of Workforce and Organisational Development	-
8.4	Payroll	Finance Director	Deputy Finance Director	-
8.4.3	Time Records, termination forms	Finance Director	Nominated Managers	See Directorate Authorised signatory lists
8.5	Contracts of Employment	Director of Workforce and Organisational Development	Deputy Director of Workforce and Organisational Development	-
9.1	Non-pay budgetary delegation	Chief Executive	Finance Director	See Directorate Budget Holder Manual
	Non-pay requisitions - Requisitioners - Requisition Maximum			See Directorate Authorised Signature Lists See Directorate Budget Holder Manual
9.2.4	Prepayments	Finance Director	Appropriate Director	See Directorate Budget Holder Manual
9.5	Tendering /	Finance Director	Deputy Finance	See Procurement limits

Para	Area of Responsibility	Responsible Officer	Deputy Officer	Limits of Responsibility
	Contracts		Director	
9.6	Quotations	Finance Director	Deputy Finance Director	See Procurement limits
10	Capital Investment Programme approval	Chief Executive	Finance Director	See Capital/Business case Investment limits
10.1	Business Cases	Chief Executive	-	See Capital/Business case Investment limits
10.2	Private Finance (including leases)	Chief Executive Finance Director	Finance Director Deputy Finance Director	> £600,000 <£600,000
10.3	Asset Register	Finance Director	Deputy Finance Director	-
11	Stores	Finance Director Head of Procurement Director of Pharmacy Chief Operating Officer	Deputy Finance Director Deputy Head of Procurement Clinical Services Manager Deputy Director - Operations Estates	System of control Stores Pharmaceutical Fuel
12.1	Disposals	Finance Director	Deputy Finance Director	-
12.2	Losses and Special Payments	Finance Director	Deputy Finance Director	See Losses and Special Payments limits
12.3	Bankruptcies, Liquidation and Receiverships	Finance Director	Deputy Finance Director	-
13	Computerised Financial Systems	Finance Director	Deputy Finance Director	-
14	Patients Property	Chief Executive Finance Director	Finance Director Deputy Finance Director	-
14.5	Disposal of Deceased Patients Property	Finance Director	Deputy Finance Director	i) All valuables and up to £500 cash released to relatives, if sign form of indemnity ii) Cash > £500, release valuables and cash by cheque, if sign form of indemnity iii) Cash/valuables >£5,000 refer to Finance Director, release on probate or letters of Administration
15	Charitable Funds	Board of Directors (acting as Corporate Trustee)	Charitable Funds Investment Panel [CFIP]	- > £150k - Between £5k to £150k, Fund Manager and an executive member of the Investment Panel - Fund Managers; <£5k - Retrospective approval of all transactions >£500 to CFIP
17	Retention of Documents	Chief Executive	Finance Director	-

Para	Area of Responsibility	Responsible Officer	Deputy Officer	Limits of Responsibility
18	Risk Management	Chief Executive Associate Specialist in Governance Medical Director	Finance Director	-
18.3	Insurance Arrangements	Board of Directors	Finance Director	-

In the absence of the Chief Executive, the Deputy Chief Executive takes his responsibility and signs on their behalf

2. PROCUREMENT LIMITS (Quotes and Tenders)

Financial Limit	Action
Up to £5,000	1 Written quote
£5,000 - £10,000	2 Written quotes
£10,000 - £25,000	3 Written quotes
£25,000 - £100,000	Formal tender process, likely to be not less than 3 or more tenders invited; (seek advice from Supplies)
Over £100,000	EU public procurement probably applicable; (Limit of £100,000 is for supplies items, building works limit is £3.9m. Seek advice from the Supplies Department.)

3. CAPITAL/BUSINESS CASE INVESTMENT LIMITS

Value	Business Case	Analysis/Review	Approval / Deputy
Over £1,000,000; Large schemes	Full	Deputy Director of Planning and Deputy Finance Director	Board of Directors
£200,000 - £1,000,000; Intermediate schemes	Full Business case, or outline at discretion of Finance Director	Deputy Director of Planning and appropriate Finance and General Manager	Board of Directors
£50,000 - £200,000; Intermediate schemes	Outline Business case	Deputy Director of Planning and appropriate Finance and General Manager	Deputy Chief Executive/Deputy Finance Director
£5,000 – £50,000; Small schemes	Outline Business case	Deputy Director of Planning and appropriate Finance and General	Deputy Chief Executive/Deputy Finance Director

	Manager	
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4. LOSSES AND SPECIAL PAYMENTS LIMITS

Losses and Special Payments Category	Delegated Limit £			
	Board of Directors	Chief Executive or Finance Director (in CEO absence)	Finance Director	Clinical and Operational Directors (or named Deputy in each case)
Cash Losses, Bad debts and claims abandoned	> 5,000	Up to 5,000	Up to 1,000	Nil
Fruitless payments (incl. abandoned capital schemes)	Any	Nil	Nil	Nil
Losses of bedding or linen	> 10,000	Up to 10,000	Up to 1,000	Nil
Losses of equipment or property	> 10,000	Up to 10,000	Up to 1,000	Nil
Compensation claims arising out of legal action	> 50,000 + costs	Up to 50,000 + costs	Up to 1,000	Nil
Extra contractual payments to contractors; Compensation Payments (other than above)	> 5,000	Up to 5,000	Up to 1,000	Up to 1,000
Other ex-gratia payments	> 2,000	Up to 2,000	Up to 1,000	Up to 1,000
Clinical negligence/personal injury:-				
(a) Cases settled out of court	> 50,000 + costs	Up to 50,000 + costs	Up to 50,000 + costs	Nil
(b) Other	as above	Nil	Nil	Nil
Extra-statutory or extra regulatory payments	Nil	Nil	Nil	Nil

STANDING FINANCIAL INSTRUCTIONS

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1	Mar 05	Initial Issue	Mar 06
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Status		Open	
Publication Scheme		Document Library>>Policies	
FOI Classification		Release without reference to author	
Function/Activity		Standing Financial Instructions	
Record Type		Corporate documentation	
Project Name		N/A	
Key Words		Standing, Financial, Instructions, Finance	
Standard		N/A	
Scope / Location		Trust-wide	
Author		Finance	Date
Approval and/or Ratification Body		Audit Committee Board of Directors	Sept 16

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1. INTRODUCTION

1.1 General

- 1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust's Standing Orders (SOs) of the Board of Directors. They shall have effect as if incorporated in the Standing Orders of the Trust.
- 1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board of Directors and the Scheme of Delegation adopted by the Trust.
- 1.1.3 These SFIs identify the financial responsibilities that 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 Finance Director or delegated officer.**
- 1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Finance Director **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 **FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER WHICH 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 Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Finance Director as soon as possible.

1.2 Terminology

- 1.2.1 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, the Health and Social Care (Community Health and Standards) Act 2003, National Health Service Act 2006 and other Acts relating to the National Health Service or in the Financial or other Regulations made under the Acts or in the Authorisation or Constitution shall have the same meaning in this interpretation and in addition:

“Accountable Officer” means the Officer responsible and accountable for funds entrusted to the Trust. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. In accordance with the Act, this shall be the Chief Executive.

“Authorisation” means the authorisation of the Trust by NHS Improvement, the Independent Regulator of NHS Foundation Trusts.

“Board of Directors” means the Chair, non-executive directors and the executive directors appointed in accordance with the Trust’s Constitution.

“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.

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

“Chair” is the person appointed in accordance with the Constitution to lead the Board of Directors and the Board of Governors. The expression “the Chair” shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

“Chief Executive” means the chief officer of the Trust.

“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.

“Committee” means a committee appointed by the Board of Directors.

“Committee Members” means a person formally appointed by the Board of Directors to sit on or to chair specific committees.

“Constitution” means the constitution of the Trust as approved from time to time by NHS Improvement.

“Contracting and Procuring” means the system 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.

“Finance Director” means the chief finance officer of the Trust.

“Executive Director” means a director who is an officer of the Trust appointed in accordance with the Constitution. For the purposes of this document, “Director” shall not include an employee whose job title incorporates the word Director but who has not been appointed in this manner.

“Funds Held on Trust” shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived from the National Service Act 2006.

“Legal Adviser” means the properly qualified person appointed by the Trust to provide legal advice.

“Nominated Officer” means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

“Non-Executive Director” means a director who is not an officer of the Trust and who has been appointed in accordance with the Constitution. This includes the Chair of the Trust.

“Officer” means employee of the Trust or any other person who exercises functions for the purposes of the Trust other than solely as a Staff Governor or non-executive Director of the Trust.

“SFIs” means Standing Financial Instructions.

“SOs” means Standing Orders.

“Trust” means Harrogate and District NHS Foundation Trust.

“Vice-Chair” means the non-executive director appointed by the Board of Governors to take on the duties of Chair if the Chair is absent for any reason.

1.2.2 Wherever the title Chief Executive, Finance Director, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 Responsibilities and Delegation

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

1.3.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the 'Reservation of Powers to the Board of Directors' document.

1.3.3 The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

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

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

1.3.6 It is a duty of the Chief Executive to ensure that existing members of the Board of Directors and employees and all new appointees are notified of, and understand, their responsibilities within these Instructions.

1.3.7 The Finance Director is responsible for:

- (a) implementing the Trust's financial policies and for co-ordinating 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 Finance Director include:

- (d) the provision of financial advice to other members of the Board of Directors and employees;
- (e) the design, implementation and supervision of systems of internal financial control; and
- (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.

1.3.8 All members of the Board of Directors 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; and
- (d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.9 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.

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

2 AUDIT

2.1 Audit Committee

2.1.1 In accordance with Standing Orders the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

- (a) reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trusts activities (both clinical and non-clinical) that supports the achievements of the Trusts objectives.
- (b) ensuring there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards, liaises appropriately with external audit and provides appropriate, independent assurance to the Audit Committee, Chief Executive and Board.
- (c) reviewing the work and findings of the External Auditor appointed by the Board of Governance and considering the implications and management's response to their work.
- (d) reviewing the findings of the other significant assurance functions both internal and external to the Trust and considering the implications to the governance of the organisation.
- (e) reviewing the Annual Report and Financial Statements before submission to the Board.

2.1.2 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may need to be referred to NHS Improvement, the Independent Regulator of FTs.

2.1.3 It is the responsibility of the Finance Director to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when there is a proposal to review the provision of internal audit services.

2.2 Finance Director

2.2.1 The Finance Director is responsible for:

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

- (b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;
- (c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;
- (d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors. 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 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,
 - (iv) a detailed plan for the coming year.

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

- (a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- (b) access at all reasonable times to any land, premises, members of the Board of Directors or employees of the Trust;
- (c) the production of any cash, stores or other property of the Trust under a member of the Board of Directors and employee's control; and
- (d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will systematically review, evaluate and report, in accordance with their risk-based plan, on risk management, internal control and governance arrangements. These arrangements comprise the policies, procedures and operations in place to:

- (a) establish and monitor the achievement of the organisation's objectives.

- (b) identify, assess and manage the risks to achieving the organisations objectives.
- (c) ensure the economical, effective and efficient use of resources.
- (d) ensure compliance with established policies (including behavioural and ethical expectations), procedures, laws and regulations.
- (e) safeguard the organisation's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption.
- (f) ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes.

2.3.2 Whenever a matter arises that 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 Finance Director must be notified immediately.

2.3.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust. The Head of Internal Audit has the right to report directly to the Chief Executive of the Board of Directors if, in his/her opinion, the circumstances warrant this course of action.

2.3.4 The Head of Internal Audit shall be accountable to the Finance Director. The reporting system for internal audit shall be agreed between the Finance Director, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.3.5 The reporting process agreed is that the Internal Audit department will issue a formal written audit report to the appropriate managers and Executive Directors at the conclusion of each piece of audit work, within an appropriate timescale.

2.3.6 A summary of reports and an annual report will be presented to the Audit Committee.

2.4 Fraud and Corruption

2.4.1 In line with their responsibilities, the Trust Chief Executive and Finance Director shall monitor and ensure compliance *with NHS Protect Standards for providers - Fraud, bribery and corruption.*

2.4.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as required by NHS Protect Standards for providers – Fraud, bribery and corruption and the NHS Anti-fraud manual.

2.4.3 The Local Counter Fraud Specialist shall report to the Trust Finance Director and shall work with staff in NHS Protect in accordance with the NHS Anti-fraud manual.

2.5 External Audit

2.5.1 The external auditor is appointed by the Board of Governors from an approved list recommended by the Board of Directors and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. Should there appear to be a problem then this should be raised with the external auditor and referred on to the Board of Governors. If the issue cannot be resolved by the Board of Governors it should be reported to NHS Improvement.

2.6 Security Management

2.6.1 The Chief Operating Officer will monitor and ensure compliance with Directions issued directly by the Secretary of State for Health or NHS Protect on NHS security management. The Local Security Management Specialist (LSMS) will report annual to the Audit Committee on the Security Management work plan.

3 BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of Business Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board of Directors an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

- (a) a statement of the significant assumptions on which the plan is based;
- (b) details of major changes in workload, delivery of services or resources required to achieve the plan.

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

- (a) be in accordance with the aims and objectives set out in the annual business plan as submitted to NHS Improvement;
- (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; and
- (e) identify potential risks.

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

3.1.4 All budget holders must provide information as required by the Finance Director to enable budgets to be compiled and monitoring reports to be prepared.

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

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

3.2 Budgetary Delegation

3.2.1 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; and
- (f) the provision of regular reports.

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

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

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 Budgetary Control and Reporting

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

- (a) monthly/quarterly financial reports to the Board of Directors in a form approved by the Board of Directors containing:
 - (i) income and expenditure to date showing trends and forecast year-end position;
 - (ii) movements in working capital;
 - (iii) capital project spend and projected outturn against plan;
 - (iii) explanations of any material variances from plan;
 - (iv) details of any corrective action where necessary and the Chief Executive's and/or Finance Director'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.

3.3.2 Each Budget Holder is responsible for ensuring that:

- (a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;
- (b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;
- (c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board of Directors: and
- (d) all appointments to new posts to be authorised by specific approval of the Director of Workforce and Organisational Development.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements, cost reductions and efficiencies and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

3.4 Capital Expenditure

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI Section 10.)

3.5 Monitoring Returns

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation e.g. NHS Improvement (the Independent Regulator of NHS Foundation Trusts).

4 ANNUAL ACCOUNTS AND REPORTS

- 4.1 The Finance Director shall prepare and submit Annual Accounts in accordance with directions given by NHS Improvement. These directions, giving instructions regarding the methods and principles according to which the Accounts are to be prepared, together with instructions as to the form and content of the Accounts are contained within NHS Improvement's FT Annual Reporting Manual (FT ARM). This manual is the reference text used for completion of the Trust's Annual Accounts.
- 4.2 The Annual Accounts must be formally approved by the Board of Directors.
- 4.3 Following the external audit, the Accounts of the Trust, together with the auditor's report upon them, must be made available to the public.
- 4.4 A public meeting must be held at which the following must be presented:
- (a) the Annual Report of the Trust,
 - (b) the audited Accounts of the Trust and the related auditor's report,
 - (c) the audited Accounts of the funds held on trust and the related auditor's report, and
 - (d) any auditor's report in the public interest.

The meeting should be held no later than the 30 September following the end of the year to which the Accounts relate.

The content of the Annual Report is also prescribed in NHS Improvement's FT ARM.

5 BANK AND GBS ACCOUNTS, INVESTMENT AND EXTERNAL BORROWING

5.1 General

5.1.1 The Finance Director is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account NHS Improvement's guidance/directions.

5.1.2 The Board of Directors shall approve the banking arrangements.

5.2 Bank and GBS Accounts

5.2.1 The Finance Director is responsible for:

- (a) All Government Banking Service (GBS) and commercial bank accounts held in the Trust's name, no bank accounts are to be opened in the Trust's name without the prior authorisation of the Finance Director;
- (b) establishing separate bank accounts for the Trust's charitable funds;
- (c) ensuring payments made from GBS accounts do not exceed the amount credited to the account except where arrangements have been made; and
- (d) reporting to the Board of Directors all instances where bank accounts may become or have become overdrawn (together with the remedial action taken).

5.3 Banking and Investment Procedures

5.3.1 The Finance Director will prepare detailed instructions on the operation of GBS and other bank accounts that must include:

- (a) the conditions under which GBS and other bank accounts are to be operated;
- (b) the limit to be applied to any overdraft; and
- (b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

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

5.4 Investments

5.4.1 The Finance Director will comply with the Trust Treasury Management Policy, as approved by the Board of Directors, when borrowing and investing surplus funds.

5.5 External Borrowing

5.5.1 The Finance Director will advise the Board concerning the Trust's ability to pay interest on, and repay, both Public Dividend Capital and any proposed borrowing.

5.5.2 Any application for a loan or overdraft will only be made by the Finance Director or by an employee so delegated by him/her.

5.5.3 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement must be authorised as outlined in the bank mandate.

5.5.4 All long term borrowings must be consistent with the plans outlined in the current Business Plan. Any long term borrowing not included in the current Business Plan must be approved by the Board of Directors.

5.6 Review of Banking Services

5.6.1 The Finance Director should monitor performance of banking services providers to ensure that they reflect best practice and represent best value for money.

5.6.2 The Finance Director will report at least every 5 years on the review of banking services to the Audit Committee.

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

6.1 Income Systems

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

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

6.2 Fees and Charges

6.2.1 The Trust shall follow the latest national guidance on Payment by Results when entering into contracts for patient services.

6.2.2 The Finance Director is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by Statute/national tariff. 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.

6.2.3 The Finance Director shall determine the appropriate charges or fees for the provision of non-NHS services provided to commercial organisations.

6.2.4 It is the responsibility of all employees to inform the Finance Director promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions. Where an invoice is required ALL invoice requests must be sent to the Finance Department, no wards or departments are authorised to send their own "invoices".

6.3 Debt Recovery

6.3.1 All staff have an overriding responsibility to collect fees due for the provision of chargeable services thus ensuring the minimisation of debts.

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

6.3.3 Income not received should be dealt with in accordance with losses procedures. (See section 12.)

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

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The Finance Director 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; and
- (d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

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

6.4.3 All cheques, postal orders, cash etc., shall be banked promptly unless the weekly value of receipts is less than £100 (**but not less than once a month**) and intact. Disbursements shall not be made from cash received, except under arrangements approved by the Finance Director.

6.4.4 The holders of safe keys shall not accept 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 NHS SERVICE CONTRACTS FOR PROVISION OF SERVICES

- 7.1 The Chief Executive, as the accountable officer, is responsible for ensuring the Trust enters into suitable legally binding service contracts with service commissioners for the provision of NHS services. All service contracts should aim to implement the agreed priorities contained within the Trust's Business Plan. In discharging this responsibility, the Chief Executive should take into account:
- the licence from NHS Improvement
 - the standards of service quality expected;
 - the relevant national service framework (if any);
 - the provision of reliable information based on Payment by Results and HRGs
 - the National Institute of Clinical Excellence
 - the National Standard Local Action – Health and Social Care Standards and Planning Framework
 - that service contracts build, where appropriate, on existing partnership arrangements;
 - that service contracts are based on integrated care pathways.
- 7.2 A good service contract 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.
- 7.3 The Chief Executive, as the accountable officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from the service contract. This will include information on costing arrangements, which increasingly should be based upon case mix adjusted measures including Healthcare Resource Groups (HRGs). The service contract will also meet the minimum standards of the Payment by Results requirements.

8 TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EMPLOYEES

8.1 Remuneration and Terms of Service

8.1.1 In accordance with Standing Orders the Board of Directors shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Remuneration Committee will:

- (a) advise the Board of Directors about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors employed by the Trust and other senior employees including:
 - (i) all aspects of salary (including any performance-related elements/bonuses);
 - (ii) provisions for other benefits, including pensions and cars;
 - (iii) arrangements for termination of employment and other contractual terms;
- (b) make such recommendations to the Board of Directors on the remuneration and terms of service of officer members of the Board of Directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust’s circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate; and
- (c) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

8.1.3 The Committee shall report in writing to the Board of Directors the basis for its recommendations. The Board of Directors shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Board of Directors’ meetings should record such decisions.

8.1.4 The Board of Directors will after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

8.1.5 The Trust will pay allowances to the Chairman and Non-Executive Directors of the Board of Directors said allowances will be approved by the Board of Governors.

8.2 Funded Establishment

- 8.2.1 The work force plans of the Trust will be reconciled with the funded establishments on expenditure budgets, to ensure affordability of appropriate staffing levels.
- 8.2.2 The funded establishment of any department may not be varied recurrently without the approval of the Chief Executive, on the advice of the Director of Workforce and Organisational Development.

8.3 Staff Appointments

- 8.3.1 No Executive Director 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; and
 - (b) within the limit of his approved budget and funded establishment.
- 8.3.2 The Board of Directors will approve policies/procedures presented by the Director of Workforce and Organisational Development for the determination of commencing pay rates, condition of service, etc, for employees.

8.4 Processing Payroll

- 8.4.1 The Finance Director is responsible for:
- (a) specifying timetables for submission of properly authorised time records and other notifications;
 - (b) the final determination of pay and allowances (in conjunction with the Director of Workforce and Organisational Development);
 - (c) making payment on agreed dates; and
 - (d) agreeing method of payment.
- 8.4.2 The Finance Director 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 or bank credit 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
- (m) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

8.4.3 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 Finance Director's instructions and in the form prescribed by the Finance Director; and
- (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 Finance Director must be informed immediately.
- (d) taking responsibility for managing staff costs within the available resources and engaging staff in accordance with Trust policies and procedures.

8.4.4 Regardless of the arrangements for providing the payroll service, the Finance Director 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.

8.5 Contracts of Employment

8.5.1 The Board of Directors shall delegate responsibility to the Director of Workforce and Organisational Development for:

- (a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment legislation; and
- (b) dealing with variations to, or termination of, contracts of employment.

9 NON-PAY EXPENDITURE

9.1 Delegation of Authority

9.1.1 As part of the approval of annual budgets, the Board of Directors will approve the level of non-pay expenditure and the Chief Executive will determine the level of delegation to budget managers as part of the budget management framework.

9.1.2 The Chief Executive will set out:

- (a) the list of managers who are authorised to place requisitions for the supply of goods and services; and
- (b) the maximum level of each requisition and the system for authorisation above that level.

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

9.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Estates or Supplies department shall be sought. Where this advice is not acceptable to the requisitioner, the Finance Director (and/or the Chief Executive) shall be consulted.

9.2.2 The Finance Director 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.

9.2.3 The Finance Director will:

- (a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;
- (b) prepare procedural instructions 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 Directors/employees (including specimens of their signatures) authorised to certify invoices.
 - (ii) 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.
 - (iii) A timetable and system for submission to the Finance Director of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts (where providing good value for money) or otherwise requiring early payment.
 - (iv) 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, (except as below).

9.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

- (a) prepayments are only permitted where the budget holder is satisfied that the financial advantages outweigh the disadvantages. Examples of typical prepayments would include lease payments and maintenance contract payments.
- (b) the Finance Director 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); and
- (c) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.5 Official orders must:

- (a) be consecutively numbered;
- (b) be in a form approved by the Finance Director;
- (c) state the Trust's terms and conditions of trade; and
- (d) only be issued to, and used by, those duly authorised by the Chief Executive.

9.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Finance Director and that:

- (a) all contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Finance Director in advance of any commitment being made;
- (b) contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement and comply with the White Paper on Standards, Quality and International Competitiveness (CMND 8621);
- (c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health/NHS Improvement;
- (d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
 - (i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

- (ii) conventional hospitality, such as lunches in the course of working visits;

(See the Trust's Gift and Hospitality Policy).

- (e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Finance Director 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 or purchases from petty cash;
- (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 directors/employees and officers authorised to certify invoices are notified to the Finance Director;

9.3 Petty Cash

9.3.1 Purchases that will be reimbursed from petty cash are restricted in value and by type, in accordance with instructions issued by the Finance Director.

9.3.2 All reimbursements must be supported by receipt(s) and certified by an authorised signatory.

9.3.3 Petty cash records are maintained in a form as determined by the Finance Director.

9.4 Building and Engineering Transactions

9.4.1 The Finance Director shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions are appropriate. Whilst the Chief Operating Officer will ensure that the same contract and property transactions comply with the guidance contained within Strategic framework for the efficient management of healthcare estates and facilities.

9.5 Tendering Procedure (also see appendix one)

9.5.1 The trust shall ensure that competitive tenders are invited for the supply of goods, materials, manufactured articles and services; for the design, construction and maintenance of buildings and engineering works; and for disposals.

9.5.2 The waiving of competitive tendering procedures should not be used to avoid competition or administration convenience or to award further work to a consultant originally appointed through a competitive process. However formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive where;

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £25,000; or

(b) where the supply is proposed under special arrangements / contracts negotiated by DOH Procurement(or equivalent national contracting organisation), NHS Supply Chain(or equivalent national contracting organisation), North of England NHS Procurement Collaborative(or equivalent regional contracting organisation), Crown Commercial Services(or equivalent pan government procurement organisation)or locally by the Trust, in which the special arrangements / contracts must be complied with; or

(c) the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or

(d) specialist expertise is required and is available from only one source; or

(e) 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; or

(f) there is 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; or

(g) where provided for in the Department of Health's Capital Investment Manual.

(h) for building schemes over £1,000,000 (either a single or combined scheme) the Department of Health's National Framework Agreement NHS ProCure 21+ will be the normal procurement route for both publicly funded schemes and PFI.

9.5.3 Where it is decided that competitive tendering is not applicable and should be waived by virtue of (c) to (f) above, the fact of the waiver and the reasons

should be documented and reported to the Chief Executive, Finance Director and Audit Committee.

- 9.5.4 All invitations to tender should be sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods, materials or undertake the service required.
- 9.5.5 The firms/individuals invited to tender (and where appropriate quote) should be selected as set out in the tendering procedures incorporated in Appendix one.

9.6 Quotation

- 9.6.1 Quotations are required where the formal tendering procedures are waived under 9.5.2 (a) or (c) and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000.
- 9.6.2 All quotations should be treated as confidential and should be retained for inspection.
- 9.6.3 The Chief Executive or his nominated officer should evaluate the quotations and select the one which gives best value for money. If this is not the lowest, then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.
- 9.6.4 Where tenders or quotations are not required, because expenditure is below £5,000 the Trust shall procure goods and services in accordance with procurement procedures approved by the Board of Directors.
- 9.6.5 The Chief Executive shall be responsible for ensuring the best value for money can be demonstrated for all services provided under contract or in-house. The Board of Directors may also determine from time to time that in-house services should be market tested by competitive tendering. (Standing Order 9)
- 9.6.6 The competitive tendering or quotation procedure shall not apply to the disposal of:
- (a) Items with an estimated sale value of less than £10,000;
 - (b) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction;
 - (c) Obsolete or condemned articles and stores; which may be disposed of in accordance with the supplies policy of the Trust.

10 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

10.1 Capital Investment

10.1.1 The Chief Executive or nominated officer:

- 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; and
- c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

10.1.2 For every capital expenditure proposal the Chief Executive or nominated officer shall ensure:

- (a) that a business case 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; and
 - (ii) appropriate project management and control arrangements;
 - (iii) the involvement of appropriate Trust personnel and external agencies; and
- (b) that the Finance Director has certified professionally to the costs and revenue consequences detailed in the business case.
- (c) For projects over £200,000 the production of a full business case or outline is at the discretion of the Finance Director, with advice from the Planning Department.

10.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the "Strategic framework for the efficient management of healthcare estates and facilities". The Finance Director shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

10.1.4 The approval of the capital investment programme shall not constitute approval for the initiation of expenditure on any scheme.

10.1.5 The Deputy Director of Planning shall issue to the manager responsible for any scheme:

- (a) specific authority to commit expenditure;
- (b) authority to proceed to tender;
- (c) approval to accept a successful tender.

10.1.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Capital Investment Manual guidance and the Trust's Standing Orders.

10.1.5 The Finance Director shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures will:

- (a) be designed to ensure that each project stays within estimated/budgeted costs at each milestone;
- (b) be issued to project managers and other employees/persons involved in capital projects;
- (c) incorporate simple checklists designed to ensure that important requirements are complied with on each project.

10.2 Private Finance (including leasing)

10.2.1 Operating leases must be signed by the Finance Director or nominated officer.

10.2.2 When the Trust proposes to use finance, the following procedures shall apply:

- (a) The Finance Director shall demonstrate that the use of private finance represents value for money.
- (b) The proposal must be specifically agreed by the Board of Directors.
- (c) Any finance lease must be agreed and signed by the Finance Director.
- (d) The Trust will submit a business case for the capital loan.

10.3 Asset Registers

10.3.1 The Chief Executive is responsible for the maintenance of Registers of Assets, taking account of the advice of the Finance Director concerning the form of any register and the method of updating, and arranging for a physical check of assets.

10.3.2 The Trust shall maintain an Asset Register recording fixed assets. The minimum data set to be held within these registers shall be determined by the Trust ensuring compliance with NHS Improvement's FT ARM.

10.3.3 Additions to the Fixed Asset Register must be clearly identified by an appropriate budget holder and be validated by reference to:

- (a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
- (b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and
- (c) lease agreements in respect of assets held under a finance lease and capitalised.

10.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

10.3.5 The Finance Director shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on Fixed Asset Registers.

10.3.6 The value of each asset shall be depreciated using methods and rates in accordance with NHS Improvement's FT ARM.

10.3.7 The Finance Director of the Trust shall calculate and pay dividends on Public Dividend Capital in accordance with NHS Improvement's FT ARM.

10.4 Security of Assets

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

10.4.2 Asset control procedures (for purchased assets and donated assets) must be approved by the Finance Director. These procedures shall make provision for:

- (a) recording of 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 all costs associated with the retention of an asset.

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

10.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to Trust property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

10.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and employees in accordance with the procedure for reporting losses.

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

10.4.7 Equipment and other assets may be loaned to or from the Trust. Employees and managers must ensure that the Trusts management procedure is followed, in particular conditions attaching to the loan are documented and the assets identified. Assets loaned to the Trust must not be entered in the Trust's asset register.

11 STORES AND RECEIPT OF GOODS

- 11.1 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.
- 11.2 Subject to the responsibility of the Finance Director for the systems of control, overall responsibility for the control of stores shall be delegated to the Trust's Head of Procurement and Supply. The day-to-day responsibility may be delegated by Head of Procurement and Supplies to departmental employees and stores managers/keepers. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal shall be the responsibility of a designated Estates Manager and the control of any Theatres stocks shall be the responsibility of a designated Theatres Manager. The day to day responsibility for the community loan stores/wheelchairs shall be delegated to the appropriate Operation Director/Manager.
- 11.3 A number of principles apply to the operation of all stores; managers of stores and stock are responsible for ensuring that:-
- (a) stocks are kept to a minimum, commensurate with delivery and cost effective purchasing;
 - (b) delegation of responsibility must be clearly defined and recorded. The Finance Director may require access to the record in writing;
 - (c) the designated manager must be responsible for security arrangements; the custody of keys etc must be clearly defined in writing;
 - (d) security measures, including marking as Trust property, must be commensurate with the value and attractiveness of the stock;
 - (e) stocktaking arrangements are agreed with the Finance Director and a physical check undertaken at least once a year;
 - (f) the system of store control, including receipt and checking of delivery notes etc, is agreed with the Finance Director;
 - (g) there is a system, approved by the Finance Director, for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Procedures for the disposal

of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods;

- (h) any evidence of significant overstocking and of any negligence or malpractice shall be reported to the Finance Director;
- (h) losses and the disposal of obsolete stock are reported to the Finance Director.

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

11.5 For goods supplied via the NHS Supply Chain 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 (the delivery notes should be retained by the authorised person).

12 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

12.1 Disposals and Condemnations

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

12.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Finance Director of the estimated market value of the item, taking account of professional advice where appropriate. The Finance Director shall ensure that the arrangements for the sale of disposable assets maximise the income to the Trust.

12.1.3 All unserviceable articles shall be:

- (a) condemned or otherwise disposed of by an employee authorised for that purpose by the Finance Director;
- (b) recorded by the Condemning Officer in a form approved by the Finance Director that 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 Finance Director.

12.1.4 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 Finance Director who will take the appropriate action.

12.2 Losses and Special Payments

12.2.1 The Finance Director must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Finance Director must also prepare a Fraud and Corruption Policy that sets out the action to be taken both by the persons detecting a suspected fraud and those persons responsible for investigating it.

12.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Finance Director or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Finance Director and/or Chief Executive. When an employee discovers or suspects fraud or corruption it must be immediately reported to the Trust's Local Counter Fraud Specialist –

telephone no. (01904) 725145. Alternatively, employees can contact the NHS Fraud and Corruption Reporting Line (0800) 028 4060. Where a criminal offence is suspected, the Finance Director must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Finance Director or Local Counter Fraud Specialist must inform the relevant CFOS regional team in accordance with Secretary of State's Directions.

12.2.3 The Finance Director or Local Counter Fraud Specialist must notify the NHS Counter Fraud Service and both the Internal and External Auditor of all frauds.

12.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Finance Director must immediately notify:

- (a) the Board of Directors,
- (b) the External Auditor, and
- (c) the Head of Internal Audit.

12.2.5 The delegated limits for approval of all losses and special payments are set out in section 4 of SFI delegated limits. Authorising officers must undertake fuller reviews of systems to reduce the risk of similar losses occurring in the future and seek advice where they believe a particular case raises issues of principle

12.2.6 For any loss, the Finance Director should consider whether any insurance claim could be made.

12.2.7 The Finance Director shall maintain a Losses and Special Payments Register in which write-off action is recorded. This register will be reviewed by the Audit Committee on an annual basis.

12.2.8 No special payments exceeding delegated limits advised by the Department of Health (see Scheme of Delegation for details) shall be made without the prior approval of the Board of Directors.

12.3 Bankruptcies, Liquidation and Receiverships

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

12.3.2 When a bankruptcy, liquidation or receivership is discovered, all payments should cease pending confirmation of the bankruptcy etc. As a matter of urgency, a statement must be prepared listing the amounts due to and from the Trust.

13 COMPUTERISED FINANCIAL SYSTEMS

- 13.1 The Finance Director, 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 he/she 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 he/she may consider necessary are being carried out.
- 13.2 The Finance Director shall satisfy him/herself 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 will be obtained from them prior to implementation.
- 13.3 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of NHS bodies in the locality/region wish to sponsor jointly) all responsible directors and employees will send to the Finance Director:
- (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.
- 13.4 The Finance Director 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.

- 13.5 Where another health organisation or any other agency provides a computer service for financial applications, the Finance Director shall periodically seek assurances that adequate controls are in operation.
- 13.6 Where computer systems have an impact on corporate financial systems the Finance Director shall satisfy him/herself that:
- (a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
 - (b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
 - (c) Finance Director staff have access to such data; and
 - (d) such computer audit reviews are being carried out as are considered necessary.

14 PATIENTS' PROPERTY

14.1 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.

14.2 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,
- 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.

14.3 The Finance Director 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 patient's money in order to maximise the benefits to the patient.

14.4 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.

14.5 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.

14.6 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.

14.7 Where a deceased patient is intestate and there is no lawful next-of-kin, details of any monies or valuables should be notified to the Treasury Solicitor.

14.8 Any funeral expenses necessarily borne by the Trust in respect of a deceased patient shall be reimbursed from any of the patient's monies held by the Trust.

15 CHARITABLE FUNDS

15.1 Introduction

15.1.1 Charitable funds are those funds which are held in the name of the Trust separately from other funds and which arise principally from gifts, donations, legacies and endowments made under the relevant charities legislation.

15.1.2 Standing Orders state the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to its dual accountabilities to the Charity Commission for charitable funds held on trust and to the *Secretary of State* for all funds held on trust.

15.1.3 The reserved powers of the Board of Directors and the Scheme of Delegation make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

15.1.4 As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on trust.

15.1.5 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

15.2 Income

15.2.1 All gifts and donations accepted shall be received and held in the name of the Trust's registered charity and administered in accordance with the Trust's policy, subject to the terms of the specific charitable fund.

15.2.2 All managers/employees who receive enquiries regarding legacies shall keep the Finance Director, or person nominated by him, informed and shall keep an appropriate record. After the death of a benefactor all correspondence concerning a legacy shall be dealt with on behalf of the Trust by the Finance Director.

15.2.3 The Finance Director shall advise the Corporate Trustee (the Trust's Board of Directors) on the financial implications of any proposal for material fund raising activities which the Trust may initiate, sponsor or approve. Should clarification be required about materiality please contact the Finance Director.

15.2.4 New charitable funds will only be opened where the wishes of benefactors cannot be accommodated within existing funds and in all cases must comply with the requirements of the Charity Commission.

15.3 Expenditure

15.3.1 All expenditure from charitable funds, with the exception of legitimate expenses of administering and managing those funds must be for the benefit of the NHS.

15.3.2 Expenditure of any charitable funds shall be conditional upon the goods and services being within the terms of the appropriate charitable fund and upon the proviso that the expenditure does not result in further payments by the Trust which have not been agreed and funded.

15.4 Investments

15.4.1 Charitable funds shall be invested by the Finance Director in accordance with the Trust's policy and statutory requirements.

15.4.2 In managing the investments the Trust shall take due account of the written advice received from its duly appointed Investment Advisors.

16 ACCEPTANCE OF GIFTS BY STAFF

- 16.1 The Finance Director shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the *Department of Health* Standards of Business Conduct for NHS Staff.

17 RETENTION OF DOCUMENTS

- 17.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with Department of Health guidelines “Records Management: NHS Code of Practice” (currently product numbers 270422/1 & 291514/2).
- 17.2 The documents held in archives shall be capable of retrieval by authorised persons.
- 17.3 All the above shall be in compliance with the requirements of the Freedom of Information act and the Trusts policy for document management and retention.

18 RISK MANAGEMENT AND INSURANCE

18.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with the terms of the licence issued by NHS Improvement. This programme will be approved and monitored by the Board of Directors.

18.2 The programme of risk management shall include:

- a) a process for identifying and quantifying principal risks and potential liabilities, existing controls, additional controls as identified in the corporate risk register;
- b) engendering among all levels of staff a positive attitude towards the control of risk as described in the Trust Risk Management Strategy;
- 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) review arrangements including; external audit, internal audit, clinical audit, health and safety review;
- f) monitor progress against the standards for better health;
- g) receive and review annual plan at Board of Directors.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of internal control within the Annual Report and Accounts as required by the guidance issued by NHS Improvement.

18.3 The Board of Directors shall review the insurance arrangements for the Trust.

Appendix one.

Intermediate And Small Capital Schemes Tendering Procedure

Invitation To Tender

1. All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:
 - a. a plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word 'Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender); or
 - b. In a special envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.
2. Every tender for goods, materials, manufactured articles supplies as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms.
3. Every tender for building and engineering works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or other E.C.C. (Procure 21+) standard forms of contract amended to comply with the "Strategic framework for the efficient management of healthcare estates and facilities". When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form MF1) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers. The standard documents should be amended to comply with the Strategic framework for the efficient management of healthcare estates and facilities and, in minor respects, to cover special features of individual projects.
4. Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tenderer must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.
5. When tenders are invited the Deputy Director of Planning will forward a list of the prospective tenderers to the Chief Executive or an officer nominated by them showing the closing time and date(s) for each. In the instance that these tenders are not in relation to the Capital Design Team, then the Chief Operating Officer will forward the list accordingly.

Receipt, Safe Custody And Record Of Formal Tenders

6. Formal competitive tenders shall be addressed to the Chief Executive.

7. The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.
8. The Chief Executive shall designate an officer or officers, not from the originating department, to receive tenders on his behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with the following.

Opening Formal Tenders

9. As soon as practical after the date and time stated as being the latest time for the receipt of tenders they shall be opened in the presence of two members of the Directors group or of one member and one officer from those nominated by the Chief Executive and not from the originating department.
10. Every tender received shall be endorsed with the date of opening and signed by two of those present at the opening.
11. A permanent record shall be maintained to show for each set of competitive tender invitations despatched:
 - a. the names of firms/individuals invited;
 - b. the names of and the number of firms/individuals from which tenders have been received;
 - c. the total price(s) tendered;
 - d. closing date and time;
 - e. date and time of opening;

The record shall be signed by the persons present at the opening.

12. Except as in Section 13 below, a record shall be maintained of all price alterations on tenders, i.e. where a price has apparently been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be initialled by two of those present at the opening.
13. A report shall be made on the record if, on any one tender, price alterations are so numerous as to render the procedure at Section 12 unreasonable.

Admissibility And Acceptance Of Formal Tenders

14. In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive.

15. Tenders received after the due time and date may be considered only if the Chief Executive or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Executive or nominated officer shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting.
16. Technically late tenders (i.e. those despatched in good time but delayed through no fault of the tenderer) may be regarded as having arrived in due time.
17. In complete 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) should be dealt with in the same way as late tenders.
18. Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing his offer.
19. Necessary discussions with a tenderer of the contents of his tender, in order to elucidate technical or other points before the award of a contract, need not disqualify the tender.
20. While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall be kept strictly confidential and held in safe custody by the designated officer.
21. Where only one tender/quotation is received the Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable.
22. The most economically advantageous tender/quotation 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 and such reasons shall be set out in a permanent record.
23. All Tenders should be treated as confidential and should be retained for inspection.

Lists Of Approved Firms

24. The Trust shall compile and maintain, and the Chief Operating Officer shall keep, lists of approved firms and individuals from whom tenders may be invited, and shall keep these under review. The lists shall be selected from all firms which have applied for permission to tender provided that:
 - a. in the case of building, engineering and maintenance works, the Chief Executive is satisfied on their capacity, conditions of labour, etc, and that the Finance Director is satisfied that their financial standing is adequate (see detailed Financial Procedures).
 - b. In the case of the supply of goods, materials and related services, and consultancy services the Chief Executive or the nominated officer is satisfied as to their technical competence etc, and that the Finance Director is satisfied that their financial standing is adequate.
25. In the case of building, engineering and maintenance works, the trust shall arrange to review the list, not less frequent than every fifth year, as described in the Strategic framework for the efficient management of healthcare estates and facilities.
26. If in the opinion of the Chief Executive or the Finance Director it is impractical to use a list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of firms invited to tender or quote.
27. A permanent record should be made of the reasons for inviting a tender or quote other than from an approved list.

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Standing Orders

Version	Date	Purpose of Issue/Description of Change	Review Date
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FOREWORD

NHS Foundation Trusts are required to demonstrate appropriate arrangements to provide comprehensive governance arrangements in accordance with the Health and Social Care (Community Health and Standards) Act 2003, the NHS Act 2006 and the Health and Social Care Act 2012.

Standing Orders (SOs) (*including SOs relating to the business of the Council of Governors; see Annex A*) regulate the proceedings and business of the Trust and are part of its corporate governance arrangements. In addition, as part of accepted Codes of Conduct and Accountability arrangements, boards are expected to adopt schedules of reservation of powers and delegation of powers. These schedules are incorporated within the *Reservation of Powers To the Board and Delegation of Powers, see Annex B*.

These documents, together with Standing Financial Instructions, Detailed Financial Procedures, Code of Business Conduct, Fraud and Corruption Policy and the procedures for the Declaration of Interests and Declaration of Gifts and Hospitality provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegation, Standing Financial Instructions and Detailed Financial Procedures provide a comprehensive business framework that are to be applied to all activities. The Board of Directors and all members of staff should be aware of the existence of and work to these documents.

Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

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Annex A Standing Orders of the Council of Governors

Annex B HDFT Scheme of Reservation and Delegation

INTRODUCTION

Statutory Framework

Harrogate and District NHS Foundation Trust (the Trust) is a statutory body, which came into existence on 1st January 2005 pursuant to authorisation of Monitor under the Health and Social Care (Community Health and Standards) Act 2003 ("the 2003 Act"), superseded by the NHS Act 2006 and consequently by the Health and Social care Act 2012.

For administrative purposes, Harrogate District General Hospital, Lancaster Park Road, Harrogate HG2 7SX is the Trust Headquarters

NHS Foundation Trusts are governed by the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995, the Health Act 1999 and the Health and Social Care Act 2001 and 2003, the NHS Act 2006 and the Health and Social Care Act 2012.

The functions of the Trust are conferred by this legislation and the authorisation.

As a statutory body, the Trust has specified powers to contract in its own name.

The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, and sections 75,76 and 256 of the NHS Act 2006 (previously sections 28A, 31 and 64 of the NHS Act 1977) to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

The Code of Accountability 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.

NHS Framework

The Code of Accountability requires that, inter alia, The Board of Directors draws up a schedule of decisions reserved to that Board, and ensures that management arrangements are in place to enable responsibility to be clearly delegated appropriately.

The Code also requires the establishment of a) an Audit Committee and b) a Remuneration Committee, with formally agreed terms of reference. The Code of Conduct requires a register of possible conflicts of interest of members of both the Board of Directors and the Council of Governors, and how those possible conflicts are addressed.

The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS subject for example to the Freedom of Information Act 2000.

Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. These Standing Orders set out the detail of these arrangements.

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.

Integrated Governance

The Trust Board has a fully integrated governance system in place. This ensures that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Integrated governance enables the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and quality, clinical, and financial objectives.

1. INTERPRETATION

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/she should be advised by the Chief Executive).

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, the Health and Social Care (Community Health and Standards) Act 2003, NHS Act 2006, Health and Social Care Act 2012 and other Acts relating to the National Health Service or in the Financial or other Regulations made under the Acts or in the Licence or Constitution shall have the same meaning in this interpretation and in addition:

"**ACCOUNTABLE OFFICER**" means the Officer responsible and accountable for funds entrusted to the Trust. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. In accordance with the Act, this shall be the Chief Executive.

"**AUTHORISATION**" means the authorisation of the Trust by Monitor, Healthcare Regulator.

"**BOARD OF DIRECTORS**" means the Chair, Non-Executive Directors and the Executive Directors appointed in accordance with the Trust's Constitution.

"**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.

"**CHAIR**" is the person appointed in accordance with the Constitution to lead the Board of Directors and the Council of Governors. The expression "the Chair" shall be deemed to include the Vice Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"**CHIEF EXECUTIVE**" means the chief accountable officer of the Trust.

"**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.

"**COMMITTEE**" means a committee appointed by the Board of Directors.

"**COMMITTEE MEMBERS**" means persons formally appointed by the Board of Directors to sit on or to chair specific committees.

"**CONSTITUTION**" means the Constitution of the Trust as approved from time to time by the Trust Board of Directors and Council of Governors and, where applicable, Members of the Foundation Trust.

"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.

"FINANCE DIRECTOR " means the Director of Finance who is the chief finance officer of the Trust.

"EXECUTIVE DIRECTOR" means a director who is an officer of the Trust appointed in accordance with the Constitution. For the purposes of this document, "director" shall not include an employee whose job title incorporates the word director but who has not been appointed in accordance with the Constitution

"FUNDS HELD ON TRUST" shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Sch 2 Part II para 16.1c NHS & Community Care Act 1990. Such funds may or may not be charitable.

"MOTION" means a formal proposition to be discussed and voted on during the course of a meeting.

"NOMINATED OFFICER" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"NON-EXECUTIVE DIRECTOR" means a director who is not an officer of the Trust and who has been appointed in accordance with the Constitution. This includes the Chair of the Trust.

"OFFICER" means employee of the Trust or any other person who exercises functions for the purposes of the Trust other than solely as a Staff Governor or Non-Executive Director of the Trust.

SENIOR INDEPENDENT DIRECTOR means a Non-Executive Director who is appointed by the Board of Directors in consultation with the Council of Governors to support the Chair and carry out the appraisal of the Chair. They will be available to Members and Governors of the Foundation Trust to raise concerns that contact through usual channels has not resolved.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

"TRUST" means Harrogate and District NHS Foundation Trust.

"VICE CHAIR" means the Non-Executive Director appointed by the Council of Governors to take on the duties of the Chair if the Chair is absent for any reason.

2. The Board of Directors

- 2.1 All business shall be conducted in the name of the Trust.
- 2.2 The powers of the Trust established under statute shall be exercised by the Board of Directors except as otherwise provided for in Standing Order 4.
- 2.3 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission.
- 2.4 The Board of Directors has resolved that certain powers and decisions may only be exercised or made by that Board in formal session. These powers and decisions are set out in the Reservations of Powers to the Board and Delegation of Power and appear in the Scheme of Delegation in the Standing Orders and Standing Financial Instructions.

2.5 Composition of the Trust Board

In accordance with the Trust's Constitution, the composition of the Board of Directors shall be:

- The Chair of the Trust
- A minimum of ~~six~~five Non- Executive Directors (including the Vice Chair of the Trust and Senior independent Director)

Executive Directors including:

- the Chief Executive (the Chief Accountable Officer)
- the Finance Director (the Chief Finance Officer)
- the Medical Director (who shall be a registered medical or dental practitioner)
- the Chief Nurse (who shall be a registered nurse or midwife)
- a minimum of ~~two~~one other Executive Directors (currently the ~~Director of Performance and Delivery~~Chief Operating Officer and Director of Workforce and Organisational Development)
- A Deputy Chief Executive who will be one of the above.

2.6 Role of the Board of Directors

The Board will function as a corporate decision-making body. Executive and Non-Executive Directors will be full and equal members of the Board. 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.

The Executive and Non-Executive Directors listed in paragraph 2.5 hold a vote. In addition the ~~Director of Human Resources, Director of Partnerships and Innovation and the~~ Trust's Clinical Directors attend Board of Director meetings but do not hold a vote.

(1) Executive Directors

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

(2) Chief Executive

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

(3) Director of Finance

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

(4) Non-Executive Directors

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

(5) Chairman

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

The Chairman shall liaise with the Nominations Committee, comprising of representatives from the Council of Governors over the appointment of Non-Executive Directors. Once a Non-Executive Director is appointed, the Chairman shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

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

2.7 Lead Roles for Directors

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

The allocation of additional responsibilities for Non-Executive Directors will be required from time to time in accordance with statutory requirements or guidance. These will be made by the Chairman.

2.8 Appointment of the Chair and Non-Executive Directors

The Chair and Non-Executive Directors are appointed by the Council of Governors.

Non-Executive Directors (including the Chairman) are to be appointed by the Council of Governors using the procedure set out in the Constitution.

2.9 Terms of Office of the Chair and Non-Executive Directors

The Chair and the Non-Executive Directors are to be appointed for a period of office in accordance with the Constitution. Non-Executive Directors will serve a three year period and will not normally exceed a maximum of three terms of office. After two terms of office, Non-Executive Directors are subject to annual re appointment by the Council of Governors. The terms and conditions of the office are decided by the Council of Governors at a formal Meeting.

2.10 Appointment of Vice Chair of the Board of Directors

For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Council of Governors will appoint a Non-Executive Director to be Vice Chair for such a period, not exceeding the remainder of their term as Non-Executive Director of the Trust, as they may specify.

Paragraph 3.11 sets out the provision if the Chair and Vice-Chair are absent such Non-Executive Director as the Directors present shall choose shall preside.

Any Non-Executive Director so elected may at any time resign from the office of Vice Chair by giving notice in writing to the Chair. The Council of Governors may thereupon appoint another Non-Executive Director as Vice Chair in accordance with paragraph 2.8.

2.11 Powers of the Vice Chair

Where the Chair of the Trust has ceased to hold office, or has been unable to perform duties as Chair owing to illness, absence or any other cause, references to the Chair shall, so long as there is no Chair able to perform those duties, be taken to include reference to the Vice Chair.

3. MEETINGS OF THE BOARD OF DIRECTORS

3.1 Meetings of the Board of Directors are to be held in public. There will be Terms of Reference for Board of Director meetings, agreed by the Board of Directors.

3.2 The Chairman shall give such direction as seen fit in regard to arrangements for meetings to accommodate presenters of papers and information to the Board of Directors and will ensure that business will be conducted without interruption and without prejudice. Any business that is considered to be confidential, for example that relating to matters that are commercial in confidence and relating staff members and patients will be transacted in private. The Chair has the power to exclude visitors on grounds of the confidential nature of the business to be transacted.

3.3 Calling Meetings

Ordinary meetings of the Board of Directors shall be held at such times and places as that Board may determine.

3.4 The Chair of the Trust may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a request for that purpose, signed by at least one-third of the whole number of Directors, has been presented, or if, without so refusing, the Chair does not call a

meeting within seven days after such request has been presented at the Trust's Headquarters, such one-third or more Directors may forthwith call a meeting.

3.5 Notice of Meetings

Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every director, or sent electronically or by post to the agreed address of such director, so as to be available at least three clear days before the meeting. A postal notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post. Failure to serve such a notice on more than three Directors will invalidate the meeting.

A Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.6 Lack of service of the notice on any director shall not affect the validity of a meeting.

3.7 In the case of a meeting called by Directors in default of the Chair, those Directors shall sign the notice and no business shall be transacted at the meeting other than that specified in the notice.

3.8 Agendas will be sent to Directors no less than ~~three~~five working days before the meeting and supporting papers shall accompany the agenda, save in an emergency.

3.9 Setting the Agenda

The Board of Directors may determine that certain matters as a minimum shall appear on every agenda for a meeting. These are:

- (1) The Report from the Chief Executive.
- (2) The Report from the Medical Director.
- (3) The Report from the Chief Nurse.
- (4) The Report from the Director of Finance.
- (5) The Report from the ~~Director of Performance and Delivery~~Chief Operating Officer.
- (6) The Report from the Director of ~~Human Resources~~Workforce and Organisational Development.
- ~~(7) The Report from the Director of Partnerships and Innovation.~~

3.10 A Director desiring a matter to be included on an agenda shall make a request to the ~~Deputy Director of Corporate Affairs~~Company Secretary at least seven clearworking days before the meeting. This request will

be discussed with the Chairman and Chief Executive. Requests made less than seven [working](#) days before a meeting may be included on the agenda at the discretion of the Chair.

3.11 Chair of Meeting

At any meeting of the Board of Directors the Chair, if present, shall preside. If the Chair is absent from the meeting the Vice Chair shall preside. If the Chair and Vice Chair are absent such Non-Executive Director as the Directors present shall choose shall preside.

3.12 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Vice-Chair, if present, shall preside. If the Chair and Vice-Chair are absent, or are disqualified from participating, such Non-Executive Director as the directors present shall choose shall preside.

3.13 Notices of Motion

A director desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

3.14 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.15 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the director who gives it and also the signature of 4 other directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the Chair to propose a motion to the same effect within 6 months.

3.16 Motions

The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.17 When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- An amendment to the motion.

- The adjournment of the discussion or the meeting.
- That the meeting proceed to the next business.
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion is discussed at the meeting.

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.18 Chair's Ruling

Statements of directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity, and any other matters shall be observed at the meeting.

3.19 Voting

Every question put to a vote at a meeting shall be determined by a majority of the votes of the Chair of the meeting and directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

3.20 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

3.21 If at least four of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

3.22 If a director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.23 In no circumstances may an absent director vote by proxy. Absence is defined as not being able to participate in the meeting at the time of the vote. Participation can take place by teleconference or video conference.

3.24 An officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An officer attending to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the

voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

3.25 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

3.26 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.27 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of the meeting the minutes shall be made available to the public (required by Code of Practice on Openness in the NHS and the Freedom of Information Act). A record of items discussed in private will be maintained and approved by the Board of Directors.

3.28 Suspension of Standing Orders

Except where this would contravene any statutory provision or any provision of the Licence or of the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board of Directors are present, including two Executive Directors and two Non-Executive Directors, and that a majority of those present vote in favour of suspension.

3.29 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.30 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.

3.31 No formal business may be transacted while Standing Orders are suspended.

3.32 The Audit Committee shall review every decision to suspend Standing Orders.

3.33 Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

- a notice of motion under Standing Order 3.16 has been given; and
- no fewer than half of the Trust's total Non-Executive Directors in post vote in favour of amendment; and
- at least two-thirds of the Directors are present; and

- the variation proposed does not contravene a statutory provision or provision of the licence or of the Constitution

3.34 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

3.35 Quorum

No business shall be transacted at a meeting of the Board of Directors unless at least ~~six~~four of the whole number of the Directors are present including at least ~~three~~two Executive Directors and ~~three~~two Non-Executive Directors, one of whom is the Chair and as such has a casting vote.

3.36 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.37 If the Chair or director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Orders 6 and 7) they 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. The above requirement for at least ~~three~~two Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to a provision in the Licence or the Constitution, the Board of Directors may make arrangements for the exercise, on its behalf of any of its functions

- by a committee or sub-committee.
- appointed by virtue of Standing Order 5.1 or 5.2 below or by a director or an officer of the Trust

in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

4.2 Emergency Powers

The powers which the Board of Directors has retained to itself within these Standing Orders (Standing Order 2.2) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

4.3 Delegation to Committees

The Board of Directors shall agree, as and when it deems appropriate, to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The Constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

4.4 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on its behalf by the Chief Executive. The Chief Executive shall determine which functions shall be delegated to officers to undertake

4.5 The Chief Executive shall prepare a Scheme of Delegation identifying proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

4.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance or other Executive Director to provide information and advise the Board of Directors in accordance with any statutory requirements. Outside these statutory requirements the roles of the Director of Finance,

~~Director of Performance and Delivery~~Chief Operating Officer, Medical Director, Chief Nurse and, Director of ~~Human Resources~~Workforce and Organisational Development and ~~Director of Partnerships and Innovation~~ shall be accountable to the Chief Executive for operational matters.

- 4.7** The arrangements made by the Board of Directors as set out in the "Harrogate and District NHS Foundation Trust Scheme of Reservation and Delegation" shall have effect as if incorporated in these Standing Orders.

5. COMMITTEES

5.1 Appointment of Committees

Subject to the Licence and the Constitution the Board of Directors may appoint committees of the Trust, or together with one or more stakeholder or other Trusts, appoint joint committees, consisting wholly or partly of the Chair and Directors of the Trust or other health service bodies or wholly of persons who are not Directors of the Trust or other health service bodies in question.

5.2 A committee or joint committee appointed under this regulation may, in accordance with the Constitution, appoint sub-committees consisting wholly or partly of Directors of the committee or joint committee (whether or not they are Directors of the Trust or other health service bodies in question); or wholly of persons who are not Directors of the Trust or other health service bodies or the committee of the Trust or other health service bodies in question.

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

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

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

5.6 The Board of Directors shall approve the appointments to each of the committees which it has formally constituted. Where the Board of Directors determines, and regulations permit, that persons, who are neither Directors nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors as defined by the Licence and Constitution. The Board of Directors 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 its Constitution.

5.7 The committees and sub-committees established by the Trust are:

5.7.1 The Audit Committee;

5.7.2 The Remuneration Committee for Executive Directors;

5.7.3 The Nominations Committee for Executive Directors;

5.7.4 The Charitable Funds Investment Panel

5.7.5 The Quality ~~and Governance Group~~ Committee

5.7.6 The Finance Committee

5.7.6 The Senior Management Team

Such other committees may be established, as required, to discharge the Board's responsibilities. A diagram detailing the Trust's governance structure can be found on the Trust intranet by following: <http://nww.hdft.nhs.uk/corporate/department-of-governance/governance-and-risk-management/strategy-policies-and-protocols/>

The minutes of the above committees will be made available to the Board of Directors at their meetings, with the exception of the Remuneration Committee; these meetings will be referenced by the Chairman at Board of Directors meetings however the full minutes will not be shared due to the confidential nature of discussions.

5.8 Confidentiality

A member of a formal subcommittee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

5.9

A director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if that Board or committee shall resolve that it is confidential.

6. DECLARATIONS OF INTERESTS

6.1 Declaration of Interests - The Constitution requires members of the Board of Directors to declare interests, which are relevant and material to the Board of Directors. All existing directors should declare such interests. Any directors appointed subsequently should do so on appointment.

6.2 Interests, which should be regarded as “relevant and material”, are:

- a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies).
- b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
- c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
- d) A position of authority in a charity or voluntary organisation in the field of health and social care.
- e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.
- f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

Board members are expected to declare any personal or business interest which may influence, or may be *perceived* to influence, their judgement.

6.3 At the time directors' interests are declared, they should be recorded in the Board of Directors' minutes. Any changes in interests should be officially declared at the next Board of Directors meeting following the change occurring.

6.4 Directors' Directorships of companies in 6.2.a) above likely or possibly seeking to do business with the NHS (6.2.b) above) should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports. Any changes in interests should be officially declared at the next board meeting as appropriate following the change occurring. It is the obligation of the director to inform the [Deputy Director of Corporate Affairs Company Secretary](#) of the NHS Foundation Trust in writing within seven days of becoming aware of the existence of a relevant or material interest. The [Deputy Director of Corporate Affairs Company Secretary](#) will amend the Register upon receipt of interests within three working days.

- 6.5** During the course of a Board of Directors meeting, if a conflict of interest is established, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, majority will resolve the issue with the Chair having the casting vote.
- 6.6** If directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair. The appropriate Financial Reporting Standard (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 medical practitioners should also be considered.
- [6.7 Supporting guidance relating to declaration of interests can be found in the Trust's constitution.](#)**

7. DISABILITY OF CHAIRMAN AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Order, if the Chair or a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he 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.

7.2 The Board of Directors will exclude the Chair or a director of that Board from a meeting of that Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

7.3 Any remuneration, compensation or allowances payable to the Chair or a Non-Executive Director in accordance with the Constitution shall not be treated as a pecuniary interest for the purpose of this Standing Order.

7.4 For the purpose of this Standing Order the Chairman or a director shall be treated, subject to Standing Orders 7.2 and 7.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and in the case of persons living together as partners the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.5 The Chair or a director shall not be treated as having a pecuniary interest in any proposed contract or other matter by reason only:

(a) of membership of a company or other body, if there is no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which he is connected as mentioned in Standing Order 7.4 above which is so remote or insignificant that it cannot reasonably be regarded by

the Board as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.6 Where the Chair or a director:

- (a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body:
- (b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less: and
- (c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it (without prejudice however to his/her duty to disclose his/her interest) provided the interest has been declared.

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

8. STANDARDS OF BUSINESS CONDUCT

8.1 Policy

Staff must comply with the national guidance contained in HSG(93)5 “Standards of Business Conduct for NHS staff” (contained in the Trust Code of Business Conduct). The following provisions should be read in conjunction with this document.

8.2 Interest of Officers in Contracts

If it comes to the knowledge of a director or an officer of the Trust that a contract in which he/she has any pecuniary interest (but not being a contract to which he/she is himself/herself a party), has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Chief Executive of the fact that he/she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.3 An officer must also declare to the Chief Executive any other employment or business or other relationship of his/hers, or of a cohabiting partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Trust requires interests, employment or relationships so declared by staff to be entered in a register of interests of staff.

8.4 Canvassing of, and Recommendations by, Directors in Relation to Appointments

Canvassing of directors or of the Board of Directors or the Council of Governors or members of any committee of the Board 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.

8.5 A director 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 director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust or taking part in the appointment process.

8.6 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.7 Relatives of Directors or Officers

Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship may

disqualify a candidate and, if appointed, may render him/her liable to instant dismissal.

- 8.8** The Chair, directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of Line Managers to report to the Trust any such disclosure made. Relationships to which this order applies are those of husband and wife or co-habitees or where either of the two or the spouse of either of them is the son or daughter or grandson or granddaughter or brother or sister or nephew or niece of the other or the spouse of the other.
- 8.9** On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board of Directors whether they are related to any other Director or holder of any office under the Trust.
- 8.10** Where the relationship of an officer or another director to a director of the Trust is disclosed, the Standing Order headed "Disability of the Chair and Directors in proceedings on account of pecuniary interest" (Standing Order 7) shall apply.
- 8.11** On appointment to the Trust, all Directors will be required to fulfil the requirements of the Fit and Proper Persons Test.

9. IN-HOUSE SERVICES

- 9.1** In all cases where the Board of Directors 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 supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £500,000, a Non- Executive Director should be a member of the evaluation team.
- 9.2** All groups should work independently of each other and individual officers may be a director of more than one group but no director of the in-house tender group may participate in the evaluation of tenders.
- 9.3** The evaluation team shall make recommendations to the Board of Directors.
- 9.4** The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

10. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

10.1 Custody of Seal

The Common Seal of the Trust shall be kept by the Chief Executive, or officer appointed by him/her, in a secure place.

10.2 Sealing of Documents

The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or a committee thereof or where the Board of Directors has delegated its powers. The affixing of the Seal shall be attested and signed by the Chairman (or in his/her absence a Non-Executive Director) and the Chief Executive (or in his/her absence his/her deputy).

In the event of a requirement to affix the seal prior a meeting of the Board of Directors or a committee where the Board has delegated its powers, and at the agreement of the Chairman and Chief Executive, the authorisation to affix the seal can be given retrospectively by the Board of Directors. This is applicable only when prior authorisation to proceed with the project in question has been granted by the Board of Directors.

10.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by him/her) and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating directorate).

10.4 Register of Sealing

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing). The book will be held by the ~~Chief Executive~~Company Secretary or nominated officer.

11. SIGNATURE OF DOCUMENTS

- 11.1** Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.
- 11.2** The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which that Board has delegated appropriate authority.

12. MISCELLANEOUS

12.1 Standing Orders to be given to Directors and Officers

It is the duty of the Chief Executive to ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

12.2 Documents having the standing of Standing Orders

Standing Financial Instructions, Reservation of Powers to the Board of Directors and Delegation of Powers shall have effect as if incorporated into Standing Orders.

12.3 Review of Standing Orders

Standing Orders shall be reviewed at [three-year annual](#) intervals by the Board of Directors, or as required following organisational structure or policy change. The requirement for review extends to all documents having effect as if incorporated in Standing Orders.

12.4 Overriding Standing Orders

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 of Directors for action or ratification. All members of the Board of Directors, Council of Governors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

ANNEX A

**. Council of Governors
Standing Orders****1. NOTICE**

- 1.1 The Council of Governors is to meet at least three times in each financial year in addition to the Annual Members' Meeting. Save in the case of emergencies or the need to conduct urgent business, the ~~Deputy Director of Corporate Affairs~~Company Secretary shall give at least seven days written notice of the date and place of every meeting of the Council of Governors to all Governors.
- 1.2 Meetings of the Council of Governors will normally be called at the direction of the Chairman. A meeting may also be held if ten Governors give written notice to the ~~Deputy Director of Corporate Affairs~~Company Secretary specifying the business to be carried out. The ~~Deputy Director of Corporate Affairs~~Company Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request. ~~The Deputy Director of Corporate Affairs~~The Company Secretary shall issue notice of a meeting on at least seven but not more than twenty-eight days' notice to discuss the specified business.
- 1.3 Notice of the meetings of the Council of Governors is to be given:
- 1.3.1 by notice sent by post, or by electronic mail where the Governor has provided an email address for service, to all Governors;
 - 1.3.2 by notice prominently displayed at the registered office and at all of the trust's places of business;
 - 1.3.3 by notice on the trust's website;
 - 1.3.4 by any other method approved by the Council of Governors at least seven clear days before the date of the meeting.

- 1.4 The notice must:
- 1.4.1 be given to the Council of Governors and the Board of Directors, and to the external auditors;
 - 1.4.2 state whether the meeting is an Annual Members' Meeting or a Council of Governors meeting;
 - 1.4.3 give the time, date and place of the meeting; and
 - 1.4.4 indicate the business to be dealt with at the meeting

2. QUORUM

2.1 Before a Council of Governors meeting can do business there must be a quorum present. Except where these rules say otherwise, a quorum is 12 Governors entitled to vote at the meeting, with the majority of Governors from the public constituencies.

2.2 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine and notice of the adjourned meeting shall be circulated to members of the Council of Governors. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of Governors present during the meeting is to be a quorum.

3. CONDUCT OF MEETING

3.1 It is the responsibility of the Council of Governors, the Chairman of the meeting and the ~~Deputy Director of Corporate Affairs~~[Company Secretary](#) to ensure that at any meeting:

- 3.1.1 the issues to be decided are clearly explained;
- 3.1.2 sufficient information is provided to Governors to enable rational discussion to take place; and

3.1.3 where appropriate, experts in relevant fields or representatives of special interest groups are invited to address the meeting.

3.2 The Chairman of the Trust, or in their absence, the Vice Chairman of the Trust, or in exceptional circumstances in the absence of both the Chairman and Vice Chairman, the Deputy Chairman of the Council of Governors shall preside at a meeting of the Council of Governors.

Where a conflict of interest arises for the Chairman and Vice Chairman, the Deputy Chair of the Governors shall chair that element of the meeting. In these circumstances and in the absence of the Deputy Chairman, the Governors shall elect from their members, a Governor to chair that element of the meeting. In acting as the Chairman a Governor shall have a casting vote on that issue.

3.3 Where a Governor wishes to formally pose a question at the public Council of Governors meeting, they should supply this question in writing to the ~~Deputy Director of Corporate Affairs~~Company Secretary no less than 24 hours prior to the meeting. If a query arises during the meeting that is not resolved through the discussions at the meeting, any questions to be formally posed should be supplied in writing to the ~~Deputy Director of Corporate Affairs~~Company Secretary or the Chairman.

4. VOTING

4.1 Subject to the Constitution, a resolution put to the vote at a meeting of the Council of Governors shall, except where a poll is demanded or directed, be decided upon by a show of hands.

4.2 On a show of hands or on a poll, every Governor present is to have one vote. On a poll, ~~votes may be given either personally or by proxy under arrangements laid down by the Council of Governors, and~~ every Governor is to have one vote and in no circumstances may an absent Governor vote by proxy. In the case of an equality of votes the Chairman of the meeting is to have a casting vote, unless there is a conflict of interest as set out in 3.2. in which case the acting chairman will have both a primary and a casting vote.

- 4.3 Unless a poll is demanded, the result of any vote will be declared by the Chairman and entered in the minutes of the meeting. The minutes will be conclusive evidence of the result of the vote.
- 4.4 A poll may be directed by the Chairman or demanded either before or immediately after a vote by show of hands by not less than one-tenth of the Governor present at the meeting. A poll shall be taken immediately.
- 4.5 Subject to the following provisions of this paragraph, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes.
- 4.5.1 no resolution of the Council of Governors shall be passed if all the Public Governors present unanimously oppose it.
- 4.5.2 the removal of the Chairman or another Non-Executive Director requires the approval of three-quarters of the full membership of the Council of Governors.
- 4.6 Save as set out in 4.2 the Chairman of the Council of Governors or Vice Chairman shall not have a vote at a meeting of the Council of Governors.

5 PERSONS ENTITLED TO ATTEND MEETINGS

- 5.1 All meetings of the Council of Governors are to be open to the public unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds as set out in the Constitution. The Chairman may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.
- 5.2 The Council of Governors may invite the Chief Executive or any other representatives of the Board of Directors, or a representative of the trust's external auditors or other advisors to attend a meeting of the Council of Governors.
- 5.3 The Chief Executive and any other Director ~~shall have the right to~~will be invited to attend anyall meetings of the Council of Governors

~~provided that they shall not be present for any discussion of their individual relationship with the trust.~~

6. MEANS OF ATTENDANCE

- 6.1 The Council of Governors may agree that its Governors can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

7. COMMITTEES

- 7.1 The Council of Governors may form advisory sub committees under written terms of reference to the Council of Governors which may include members of the Board of Directors and appropriate people (paid or unpaid) nominated by the Board of Directors and having relevant skills or experience. Those powers shall be exercised in accordance with any written instructions given by the Council of Governors. The Council of Governors will appoint the Chairman of any committee and shall specify the quorum. All acts and proceedings of any committee shall be reported to the Council of Governors.
- 7.2 The Council of Governors will establish a Nominations Committee for the purpose of making recommendations to the Council of Governors for the appointment of the Chairman and Non-Executive Directors.
- 7.3 The Council of Governors will establish a remuneration committee for the remuneration of the Chairman and Non-Executive Directors, and decisions will be taken at a meeting of the Council of Governors.
- 7.4 The Council of Governors may, through the ~~Deputy Director of Corporate Affairs~~Company Secretary, request that advisors assist them on any committee they appoint in carrying out their functions.

8. VALIDITY OF DECISIONS

- 8.1 Decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Council of Governors attending the meeting.

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