NHS
Harrogate and District
NHS Foundation Trust

The meeting of the Board of Directors held in public will take place at 9.00am on Wednesday 27 November 2019 in the Boardroom, Trust HQ, Harrogate District Hospital, HG2 7SX

AGENDA			
Item No.	**Item**	**Lead**	**Paper No.**
9.00am – 9.20am			
Patient Story – presented by Matron Tammy Gotts			
9.20am – 11.00am			
1.0	**Welcome and Apologies for Absence:**	Mrs A Schofield, Chairman	-
2.0	**Declarations of Interest and Register of Interests** *To declare any interests relevant to the agenda and to receive any changes to the Register of Interests*	Mrs A Schofield, Chairman	2.0
3.0	**Minutes of the Board of Directors meetings held on 25 September and 30 October 2019** *To review and approve the Minutes of the meetings*	Mrs A Schofield, Chairman	3.0
4.0	**Review Action Log and Matters Arising** *To provide updates on progress of actions*	Mrs A Schofield, Chairman	4.0
Overview by the Chairman		Mrs A Schofield, Chairman	-
5.0	**Report by the Chief Executive – *to follow***	Mr S Russell, Chief Executive	5.0
	5.1 Integrated Board Report		5.1
	5.2 Summary from Resources Committee meetings of 28 October 2019, and 25 November 2019 (to follow) *To be considered and discussed*	Mrs M Taylor, Chairman Non-Executive Director	5.2
	5.3 Finance Report *To be considered and discussed*	Mr J Coulter, Director of Finance	5.3
	5.4 Operational Performance Report *To be considered and discussed*	Mr R Harrison, Chief Operating Officer	5.4
	5.5 Medical Director Report *To be considered and discussed*	Dr D Scullion, Medical Director	5.5
	5.6 Chief Nurse Report – *to follow* *To be considered and discussed*	Mrs J Foster, Chief Nurse	5.6

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	5.7 Infection Prevention and Control – Annual Report *To be considered and discussed*	Mrs J Foster, Chief Nurse	5.7
	5.8 Workforce and Organisational Development Report *To be considered and discussed*	Ms A Wilkinson, Director of Workforce and Organisational Development	5.8
	To deliver high quality health care		
6.0	**6.0 Summary from Quality Committee meetings of 2 October and 6 November 2019** *To be considered and discussed*	Ms L Robson, Chairman Non-Executive Director	6.0
	6.1 Quality Committee Terms of Reference annual update *To be considered for approval*	Ms L Robson, Chairman Non-Executive Director	6.1
11.00am – 11.15am			
Break			
11.15am – 12.30pm			
	To work with partners to deliver integrated care		
7.0	**7.0 West Yorkshire and Harrogate Partnership, including WYAAT Annual Report**	Mr Steve Russell, Chief Executive	Verbal
	Governance		
8.0	**8.0 Minutes of the Council of Governors' meeting of 7 August 2019** *To receive and note*	Mrs A Schofield, Chairman	8.0
	8.1 Amendments to the Trust Constitution – minor changes following approval of title from Deputy Chairman of Governors to Lead Governor *To receive and approve*	Mrs A Schofield, Chairman	8.1
	8.2 Treasury Management Policy *For review and approval*	Mr J Coulter, Director of Finance	8.2
9.0	**Any other relevant business** *By permission of the Chairman*	Mrs A Schofield, Chairman	-
	Board Evaluation	Mrs A Schofield, Chairman	-
Confidential Motion – the Chairman to move: *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.*			

Harrogate and District NHS Foundation Trust

Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors' meeting held on
Wednesday 30 October 2019 at 10.00am at Ripon Community House, Allhallowgate, Ripon

Present:	Ms Sarah Armstrong, Non-Executive Director Mr Jonathan Coulter, Deputy Chief Executive/Finance Director Mrs Jill Foster, Chief Nurse Mr Robert Harrison, Chief Operating Officer Ms Laura Robson, Non-Executive Director Mr Steve Russell, Chief Executive Mrs Angela Schofield, Chairman Dr David Scullion, Medical Director, Mr Richard Stiff, Non-Executive Director Mrs Maureen Taylor, Non-Executive Director Mr Chris Thompson, Non-Executive Director/Vice Chairman Mrs Lesley Webster, Non-Executive Director Ms Angela Wilkinson, Director of Workforce and Organisational Development
In attendance:	Mr Andrew Alldred, Clinical Director, Long Term and Unscheduled Care Mr Andrew Forsyth, Interim Company Secretary Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services

1.0 Welcome and Apologies for Absence

1.1 Mrs Schofield noted there were apologies for absence from Dr Kat Johnson, Clinical Director, Planned and Surgical Care.

1.2 It was confirmed a quorum was present at the meeting.

2.0 Declarations of Interest and Board Register of Interests

2.1 It was noted Mr Coulter and Mr Thompson were Directors of Harrogate Integrated Facilities (HIF). No agenda items were planned which would present a conflict of interest.

3.0 Recruitment of Non-Executive Directors

3.1 Mrs Scofield's paper had been circulated in advance and was taken as read.

3.2 She explained the background and outlined the proposal. The recruitment process to replace Mrs Webster and Mr Thompson had yielded three good, strong candidates and it was the opinion of the interview panel that they would each bring high quality attributes to the Board.

3.3 The next Non-Executive Director was due to reach the end of their second term at the end of October 2020 and this would require the Trust to recruit a replacement. The pragmatic approach was for the Trust to engage all three candidates at this point.

3.4 The Constitution of the Trust specifies only that the Board must have a minimum of six Non-Executive Directors; the proposal was to add a seventh, but for a limited period. 3.5 Mrs Taylor said she had been impressed by the quality of the candidates and asked in which order they would be engaged, if the proposal was agreed. Mrs Schofield said that, subject to approval by the Council of Governors on 6 November, Mr Cross would be appointed from 1 January 2020 and Mr Sampson and Mr Papworth from 1 March 2020. 3.6 Mrs Foster asked about the balance of Executive against Non-Executive Director and Mrs Schofield said that there must always be a majority of Non-Executive Directors and the proposal did not cause this to be lost. 3.7 Mrs Webster commented that the services of Gatenby Sanderson had generated a better pool of candidates. 3.8 The Board of Directors approved the proposals that, subject to approval of the preferred candidates by the Council of Governors, a seventh Non-Executive Director should be appointed from 1 March 2020 to 31 October 2020, at which point the seventh post would lapse.
APPROVED: **The Board of Directors approved the establishment of a seventh, time-limited, Non-Executive Director post on the Board of Directors and agreed that the tenure of the holder of the seventh Non-Executive Director post will run from 1 March 2020 until the next Non-Executive director vacancy occurs. This is likely to be on 31 October 2020. The post will then lapse.**
4.0 Any other relevant business not included on the Agenda
There was no other business not included on the Agenda.
5.00 Board Evaluation
There was no evaluation of the meeting.
The meeting closed at 10.20am.

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Harrogate and District NHS Foundation Trust

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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 Company Secretary and was last updated in November 2019.

Name	Position	Interests Declared
Mr Andrew Alldred	Clinical Director LTUC	1. Chair of the Yorkshire and Humber Medicines Optimisation and Procurement Committee 2. Member of the Yorkshire and Humber Chief Pharmacist group 3. Member of the West Yorkshire and Harrogate ICS Pharmacy Leadership Group 4. Chair of the Procurement sub-committee of the West Yorkshire and Harrogate ICS and Regional Partners Regional Store Project and a member of the project board
Ms Sarah Armstrong	Non-Executive Director	1. Company director for the flat management company of current residence 2. Chief Executive of the Ewing Foundation
Mr Jonathan Coulter	Deputy Chief Executive/ Finance Director	1. Non-Executive Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Mrs Jill Foster	Chief Nurse	None
Mr Robert Harrison	Chief Operating Officer	1. Charity Trustee of Acomb Methodist Church, York 2. Chair of Directors of Strategy and Operations WYAAT 3. WYAAT Elective Care COO Lead 4. Harrogate Place representative on the WY&H Cancer Alliance Board 5. Member of the Harrogate and Rural Alliance Board 6. Director of ILS and IPS Pathology Joint Venture (from 1 October)
Dr Kat Johnson	Clinical Director PSC	None

Dr Natalie Lyth	Clinical Director CCCC	1. Member of North Yorkshire Local Safeguarding Children's Board and sub-committees. 2. Chair of the Safeguarding Practice Review Group. 3. Chair of the North Yorkshire and York Looked After Children Health Professionals Network. 4. Member of the North Yorkshire and York Safeguarding Health Professionals Network. 5. Member of the national network of Designated Health Professionals. 6. Member of the Royal College of Paediatrics and Child Health Certificate of Eligibility of Specialist Registration (CESR) Committee and assessor of applications for CESR.
Ms Laura Robson	Non-Executive Director	1. Familial relationship with Alzheimer's Society
Mr Steve Russell	Chief Executive	None
Mrs Angela Schofield	Chairman	1. Member of WYAAT Committee in Common 2. Vice-Chair, West Yorkshire and Harrogate ICS Partnership 3. Volunteer with Supporting Older People (charity). 4. Chair of NHSE Northern Region Talent Board
Dr David Scullion	Medical Director	1. Member of the Yorkshire Radiology Group 2. Familial relationship with Freedom to Speak Up Guardian
Mr Richard Stiff	Non-Executive Director	1. Director of (and 50% owner) Richard Stiff Consulting Limited 2. Director of NCER CIC (Chair of the Board from April 2019) 3. Director and Trustee of TCV (The Conservation Volunteers) 4. Chair of the Corporation of Selby College 5. Member of the Association of Directors of Children's Services 6. Member of Society of Local Authority Chief Executives 7. Local Government Information Unit Associate 8. Local Government Information Unit (Scotland) Associate 9. Fellow of the Royal Society of Arts
Mrs Maureen Taylor	Non-Executive Director	None

Mr Christopher Thompson	Non-Executive Director	1. Non-Executive Director of Harrogate Healthcare Facilities Management Limited (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust) 2. Director – Neville Holt Opera Limited 3. Deputy Treasurer and Member – Council of the University of York 4. Chair – NHS Audit Yorkshire Consortium 5. Chair – Tissue and Organ Donation Committee HDFT
Mrs Lesley Webster	Non-Executive Director	None
Ms Angela Wilkinson	Director of Workforce and Organisational Development	None

Harrogate and District NHS Foundation Trust

Deputy Directors attending Board meetings as substitutes

Dr David Earl	Deputy Medical Director	1. Private anaesthetic work at BMI Duchy hospital
Dr Claire Hall	Deputy Medical Director	1. HDFT representative on WYAAT Pathology group 2. HDFT representative on WYAAT Non-Surgical Oncology group 3. Member, HDFT Transfusion Committee 4. Principal Investigator for haematology trials at HDFT
Mr Jordan McKie	Deputy Director of Finance	1. Familial relationship with NMU Ltd, a company providing services to the NHS
Mrs Alison Mayfield	Deputy Chief Nurse	1. Member, WYAAT Temporary Staffing Cluster Group
Mr Paul Nicholas	Deputy Director of Performance and Informatics	None
Ms Shirley Silvester	Interim Deputy Director of Workforce and Organisational Development	None
Dr Sylvia Wood	Deputy Director of Governance & Freedom to Speak Up Guardian	1. Familial relationship with Medical Director

Harrogate and District NHS Foundation Trust

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Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors' meeting held in public on
Wednesday 25 September at 9.00am in the Boardroom at Harrogate District Hospital

Present:	Ms Sarah Armstrong, Non-Executive Director Mr Jonathan Coulter, Deputy Chief Executive/Finance Director Mr Robert Harrison, Chief Operating Officer Mrs Alison Mayfield, Deputy Chief Nurse Ms Laura Robson, Non-Executive Director Mr Steve Russell, Chief Executive Mrs Angela Schofield, Chairman Dr David Scullion, Medical Director, Mr Richard Stiff, Non-Executive Director Mrs Maureen Taylor, Non-Executive Director Mr Chris Thompson, Non-Executive Director/Vice Chairman Mrs Lesley Webster, Non-Executive Director Ms Angela Wilkinson, Director of Workforce and Organisational Development
In attendance:	Mr Andrew Alldred, Clinical Director, Long Term and Unscheduled Care Mr Richard Chillery, Operational Director, Children's and County Wide Community Services Ms Vicky Draper, Community Stroke Team Leader (Patient story only) Dr Dave Earl, Deputy Medical Director Mr Andrew Forsyth, Interim Company Secretary Dr Kat Johnson, Clinical Director, Planned and Surgical Care Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services Mr N (Patient story only) Dr Sylvia Wood, Freedom to Speak Up Guardian (item 6 only)

Patient Story

Mrs Schofield reminded Board members that the purpose of the patient story at the beginning of the meeting was to ensure that the Board was focussed on its responsibilities towards patients and members of the community by hearing about their experience of receiving care from the Trust.

Mrs Schofield welcomed Mr N, who was supported by Ms Draper, the Community Stroke Team Leader at Knaresborough Road Health Centre. Mr N had suffered a stroke at the age of 56 and wanted to cover his initial experience in hospital, his recovery period, his current situation and where he wanted to be in future.

Mr N was at home on a Saturday when he suffered his stroke. He was brought to ED and thrombolysed within two hours in the HASU – he described his treatment as brilliant. On the following day, however, he deteriorated and was totally immobilised, with a risk of pneumonia. He could not remember anything between Monday and Wednesday of that

week but slowly, and following the professional advice, he recovered and was allowed home for Christmas Day and Boxing Day. He was discharged on New Year's Eve, although he described this as rushed and he felt it was difficult to get answers to his questions about his life-changing stroke. Mr N emphasised that the staff in ED and on the wards had been both sympathetic and interested.

Once he was at home the neuro/stroke team – including physio, speech and language therapy, occupational therapy and psychology - visited him regularly. Mr N described having physio every day for 13 weeks and regaining reasonable mobility of his right arm and hand – he set himself a daily programme of exercise, with performance indicators and pushed himself. By March he had regained almost full mobility and functionality and was preparing to go back to work. He had around 50 sessions with the psychologist over 11 weeks, which had been greatly beneficial, and he went back to work on phased return in June 2019.

Mr N said that the team never missed an appointment; it was well-organised and communication with him and between the team members was good. The team had shown flexibility and teamwork.

Mrs Schofield thanked Mr N for bringing his story. He had described very openly the physical, emotional and psychological effects of his stroke and the way the team had helped him to recover. She wondered whether there had been anything which would have been different had he been admitted on a weekday. Mr Alldred said that weekend services were always under review and that the need to convey important messages in plain English was important.

Mr Thompson had seen Mr N whilst on a service visit and described the work of the team as inspirational and a Mr N as a very positive patient. Ms Robson said that community services had changed over recent years and moved to another level, to which Mr N added that not even London had a similar service. Ms Draper said that it was designed to be intensive, flexible and patient-sensitive, capitalising on the home context, before the patient was moved on to outpatient services – very much a bespoke approach.

Mrs Schofield thanked Mr No for telling his story and said that overall it had been a positive experience of the Trust's services. Mr N and Ms Draper let the meeting.

Dr Johnson said that the issue of seven-day services was difficult to change and was noticeable to patients. Dr Scullion said that Mr N had been well-treated and a combination of his self-motivation and the community team had been good. Mr Alldred noted the issue about the availability of therapy teams at weekends. Mr Harrison said that since 2012/13 the services had improved and the teams offered flexible, personalised care; a restructuring had meant that the same resources were deployed differently. A seven-day work plan would require some resource. Mrs Webster was reassured by Mr Harrison that there was no suggestion of a reduction in funding to support this team, and Mr Russell added that the trend was to bolster the service and consider combining it with the Supported Discharge Service.

ACTION:
Mrs Schofield to write to Mr N.

1.0 Welcome and Apologies for Absence

1.1 Mrs Schofield noted there were apologies for absence from Mrs Foster, Chief Nurse and Dr Natalie Lyth, Clinical Director for Children's and County Wide Community

Services, and welcomed Mrs Alison Mayfield, Deputy Chief Nurse and Mr Richard Chillery, Operational Director for Children's and County Wide Community Services in her stead.

1.2 It was confirmed a quorum was present at the meeting.

1.3 Mrs Schofield welcomed Dr Dave Earl, Deputy Medical Director and three Governors.

2.0 Declarations of Interest and Board Register of Interests

2.1 It was noted Mr Coulter and Mr Thompson were Directors of Harrogate Integrated Facilities (HIF). No agenda items were planned which would present a conflict of interest. It was, however, agreed that Mr Coulter and Mr Thompson could participate fully in any items which included reference to HIF. There were no other declarations of interest additional to those in the paper.

3.0 Minutes of the meetings of the Board of Directors on 31 July 2019

The draft Minutes of the meeting held on 31 July 2019 were approved subject to the following amendments:

Chairman's report first bullet: **Move** 'had been' **to precede** 'held' on the same line
Insert after Minute 9.4 'Mrs Webster left the meeting at this point.'

APPROVED:
The Board of Directors approved the Minutes of the meeting held on 31 July 2019 as an accurate record of the proceedings, subject to the agreed amendments.

4.0 Review of Action Log and Matters Arising

4.1 Action 131: There was now a Quality Priority around patient experience. Board Action CLOSED.
4.2 Action 136: This would be discussed at the October workshop. HaRD CCG had written to Providers.
4.3 Action 138; a bid had been submitted for the Allocate system, which included e-rostering and job-planning. The Trust was the only Trust without this system. Board Action CLOSED.
4.4 Action 140: Included on the Board agenda. Board Action CLOSED.
4.5 Action 141: Action CLOSED.
4.6 Action 144: Action CLOSED.
4.7 Action 145: Action CLOSED.
4.8 Action 147: Action moved to private meeting.
4.9 Action 149: HIF staff were included in 2018 WRES data but not 2019 data and so direct comparison year-on-year is not possible. Board Action CLOSED.

APPROVED:
The Board of Directors noted completed Actions and updates on outstanding actions.

Chairman's Report

Mrs Schofield noted a number of items:

- Active Against Cancer, a partnership between Yorkshire Cancer Network and the Trust, to promote physical and social activity for cancer patients (pre- and post-

treatment), had been inaugurated.

- The UCI Championships were underway and she said that the team had planned well for the period. They had been featured on local television. The first few days of the event had gone well, from the Trust's perspective.
- At the Board workshop in August there had been presentations and discussions about the flu vaccination campaign, property issues around ownership and working with NHS Property Services and cybersecurity training delivered by a GCHQ contracted company.
- There had been visits to community services in Harrogate and Knaresborough; Mrs Taylor had found them interesting, whilst Mrs Armstrong had been impressed with her team in action, describing them as robust together. Ms Robson had visited the Tissue Viability Service and described their delivery as spectacular, and Mr Alldred had heard HARA being valued positively by staff. Mr Russell had accompanied a physio only seven weeks into her service and said that information sharing had been good but that there was a need to be able to access hospital records of treatment given.
- Finally Mrs Schofield noted increased system working and that the Trust was working differently with HaRD CCG, helping to make a real impact with HARA.

5.0 Report by the Chief Executive

5.1 The report and Integrated Board Report (IBR) had been circulated in advance of the meeting and were taken as read.

5.2 Mr Russell started his report by thanking Mr Harrison and Ms Bowden for their work on preparations for the UCI Championships – he said the volume of work involved should not be underestimated. There had also been support from NHSE/I and great commitment from the Trust's community teams.

5.3 He noted that the transformation plan was beginning to have a positive effect although the growth in Non-Elective admissions (10% as against the forecast 2/3%), the time lag in establishing activity levels in endoscopy and the issue around referrals from Leeds were having an effect. He said it was about the Trust holding its nerve and allowing the positive progress to take effect over the coming months.

5.4 The Trust was on plan although there were pressures and risks; Directorates had developed recovery plans. Good progress was being made with North Yorkshire County Council over the 0-19 Children's Services and he would give more detail in the private session.

5.5 Moving to the complaints process Mr Russell said that there had been insufficient progress towards the target set, although the length of delay had been reduced. He said that strong views had been expressed in the RPIW but all were right and there had been a sense of team spirit by the end. He would cover the Emergency Preparedness Resilience and Response annual report in the private session but he recorded that there was no material risk to the Trust although it would report only partial compliance with the standards.

5.6 He was pleased to see that the First Line Leader programme had started and drew attention to the forthcoming RPIW on 'Clearing the Clutter', sponsored by Mr Harrison, which would lead to some system changes. Mr Russell noted that the Pathology Joint Venture with Airedale and Bradford had now been signed off to start on 1 October.

5.7 Mr Thompson asked about the position with pension taxation and Mr Harrison

replied that it was a potential contributor to longer waiting times and was included in the summary risk CR41, since it was not the only reason.

5.8 Ms Robson said she was pleased that the Complaints RPIW had been tense because it meant that the subject was being taken seriously. It had been very positive and she looked forward to seeing the actions being followed up. Mr Alldred echoed this and said it had been an excellent event with passionate staff and absolute consensus; he had been pleased that the Patient Voice Group had been involved. Learning had been at the heart of it and he looked forward to the start date on 4 November. Dr Johnson said that complaints were 'everybody's business' and that the learning, solutions and cultural change would come from the teams themselves. Mrs Webster asked about how and when the impact would be measured and Mr Russell said that there would be the usual 30, 60 and 90 day reports. The measure of success would be the 95th centile and it would be included in the IBR.

5.9 Ms Robson was concerned about the increased number of pressure ulcers recorded in the IBR and asked by whom they were being assessed. Mrs Mayfield said that grade 3 and 4 were the subject of Root Cause Analysis which included the Tissue Viability team and were signed off by the Heads of Nursing. More face to face training had been taking place with a consequent increase in the number being reported. The Trust was launching the 'Red Pillow' campaign and the process was robust. Ms Robson said the subject remained on the Quality Committee agenda for regular review. Mr Alldred noted that there was a quarterly governance report and Mrs Mayfield confirmed to Mrs Webster that the increased training had been around verification.

5.10 Dr Johnson confirmed to Ms Robson that the performance indicator for breastfeeding at 6-8 weeks was a nationally-mandated requirement. Mrs Webster asked when the Trust would change its interpretation of incidents, reflected in Indicator 1.5 and Dr Scullion said this was in hand. Dr Scullion indicated that the HSMR trend would be investigated although Dr Earl said there had been no anaesthetic deaths. Dr Scullion said that there would need to be an analysis of how the data was compiled.

To deliver high quality healthcare

6.0 Freedom to Speak Up Guardian Report

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

6.2 Dr Wood said that there were a number of interesting and exciting national initiatives. She drew attention to the shorter and more helpful self-review tool which the Board would use at the October workshop. The NHS Patient Safety Strategy chimed very much with what the Trust was doing.

6.3 Dr Wood reported that there had been a similar number of concerns reported in the Trust in 2019 to date as in 2018. Second and Third Guardians had been selected and appointed and the number of Fairness Champions had increased. She drew attention to the review of HR policies to cover conflicts of interest and that the outcome of the internal audit would be reported to the Senior Management Team.

6.4 October had been designated as Speak Up month and this would be promoted across the Trust with communications designed to raise awareness. There needed to be a suite of metrics to identify issues to be addressed and Dr Wood emphasised that the Fair,

Just and Safe culture needed to be incorporated into leadership training.

6.5 Mr Thompson asked whether the Fairness Champions took a passive or an active approach and how would their success be measured. Dr Wood replied that some were passive and some were more proactive but it was early days – she said they were not evangelists. They were linked to the culture and needed to be supported. Mr Stiff said this should be tied in with themes of learning and training needs; Ms Wilkinson emphasised that there were currently two leadership programmes which covered the implications of being a leader and included these themes and there was work in progress to improve HR advice and support.

6.6 Mrs Armstrong had found the national view and the case studies helpful, as well as the comparators. She asked whether the softer embedding had improved relationships. Mr Alldred said that was the beginning of the journey and there were some positives. Some specific work was underway with links to the leadership programmes and whilst there was a movement to speak out more there was not yet a momentum to do so. Mr Stiff looked forward to more positive feedback in time.

6.7 Mrs Schofield thanked Dr Wood for her report and suggested that the Board received quarterly reports, noting that the Guardians had the necessary direct access to both her and Mr Russell at any time. Dr Wood said that she had received full support from Mrs Schofield and Mr Russell and was able to highlight issues whenever they arose. Mrs Schofield suggested that Board members should consider becoming Fairness Champions and this could be followed up at the October Board workshop.

6.8 The Board of Directors noted the report, the plan to complete the self-review and supported the developing work on a Fair, Just and Safe culture.

7.0 Finance Report

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

7.2 Mr Coulter said that there was risk around the income from Leeds, historical payments to NHS Property Services (NHS PS) and expenditure in the Directorates. Leeds income was behind plan following their changed process but meetings had been positive and long wait patients would now be sent to HDFT; the risk was being managed. The position with NHS PS would be managed in-year although no provision had been made for it.

7.3 There were now monthly resource review meetings with the Directorates to examine progress with their recovery plans. Work was needed on winter preparations, medical devices and waiting list initiatives. It was likely that HIF would break even rather than deliver a £200k surplus. Agency usage was being managed and there was a positive move to move to full establishments, including recruit and retain measures. Mr Coulter said it was assumed that the ICS risk funding would be forthcoming and that there was no additional resource available from HaRD CCG. The cash position had improved significantly. The Trust would declare a UoR of 3, because it has a deficit plan.

7.4 Mrs Taylor said that the Resources Committee had noted the planned deficit at month 5, and also planned for month 6 but expected a turnaround in month 7. The CIP position was showing positive progress and she welcomed the change in the Leeds position. The Committee had received more workforce information and asked for more – it had noted the CSW recruitment and considered that there should be no vacancies in this role, although there were training initiatives to suit them for higher roles. The Committee had received an update

on the five year plan.

7.5 Turning to her report of the August meeting she said that the Committee had discussed the Trust's property portfolio and considered an early draft of the digital strategy.

7.6 Ms Robson asked about maternity recharges from Leeds and Mr Coulter replied that these were as the result of different parts of the pathway being delivered from maternity payments rather than the provider.

7.7 In response to a question from Mrs Schofield Mr Coulter said that he was more positive than at the same time in the previous month. Mr Harrison said in his view that HaRD CCG was accounting for its share of the risk scheme and Mr Russell shared that view.

8.0 Operational Performance Report

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

8.2 Mr Harrison said that the Trust had stopped reporting RTT against the 92% target as it was involved in the trial. He said that there were no patients waiting for 52 weeks or more and that although the waiting list numbers had grown they remained below the planned trajectory. Quarter 3 had been challenging for cancer waiting times, which had risen above 14 days; in September, however, all eight standards had been achieved, although challenges remained.

8.3 Patient attendances in the Emergency Department had risen and there had been 10% non-elective conversion against the expected 2-3%. This had placed considerable pressure on the consultants and it was intended to move to having two Middle Grade doctors on duty at night.

9.0 Medical Director Report

9.1 Dr Scullion informed that Board that he had received information about the establishment, governance and funding for the role of Medical Examiner. He would bring a report to the Board in due course.

9.2 Dr Scullion presented that Annual Medical Revalidation and Appraisal Statement of Compliance and the Board approve it for signature.

9.3 The quarterly report of the Guardian of Safe Working Hours was considered. The number of exception rendered by doctors in training remained low, and there were a similar number of vacant posts as reported in the last quarter. Version 5 of the Doctors in Training contract had now been agreed and would be implemented. The Board noted the content of the report and confirmed that SAS doctors should be given access to the Guardian where necessary, noting the points made by the Guardian in his report.

9.4 Moving to the Learning From Deaths report, which had been circulated in advance of the meeting, Dr Scullion noted that there had been more pathological fractures recorded and that there had been a reduction in the number of Structured Judgement Reviews in the period; he considered that the appointment of the Medical Examiner would have an impact on this. He drew attention to the summary of the findings of the Learning Disabilities Mortality Review Programme which was appended to the report. Ms Robson said that in her view where there had been no written record of the assessment of care, as in the case reviewed by the Medical Director, then it had not been undertaken. Dr Scullion replied that the designation of the doctor concerned had not been clear but he had been reassured that guidance had been offered.

9.5 Mrs Webster hoped that there had been learning from all of the deaths and suggested that the Board only needed to be aware that stillbirths and neonatal deaths were reported elsewhere rather than the full details included in the report.

9.6 Mrs Schofield thanked Dr Scullion for the report and said that the Board should be made more aware generally of the experience of patients with learning disabilities and Mr Harrison suggested that this should be a subject at a future Board workshop. Mrs Armstrong added that Healthwatch, both locally and nationally, was a source of advice and guidance about patients with learning disabilities.

ACTION: Mrs Foster to arrange a workshop item around patients with Learning Disabilities

10.0 Chief Nurse Report

10.1 Mrs Mayfield gave a verbal report She said that the recent visit of the Chief Executive of the Royal College of Nursing had been positive and she had been impressed with the range of services offered by the North Yorkshire 0-19 Children's Service when she had visited them in Darlington.

10.2 She asked the Board to note that there would be a recruitment event on 12 October with the targets being Theatre, Inpatient, OPD and DSU staff.

10.3 Mrs Mayfield drew attention to the new NMC employee link service. The nurse revalidation process was under review but revalidation had had a positive effect on the workforce. There were now 698,292 registered nurses and midwives (more than last year) and nursing associates would be added when the first cohort graduated in January. It had also been made easier to apply to the NMC from abroad.

To ensure clinical and financial sustainability

11.0 Workforce and Organisational Development Report

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

10.2 Ms Wilkinson noted that the sickness absence rate remained above the Trust target, with the Children's and County Wide Community Services Directorate being the highest. Stress risk assessments were being targeted. Retention was stable whilst it was necessary to recruit above the funded establishment to maintain numbers. There were 44 WTE vacancies across the wards – she said that there would be a CSW recruitment event at the end of October.

10.3 Improvements to disciplinary practices were under active consideration, following the report of incidents at Imperial College, especially around training for investigations; part of the Board October workshop would involve detailed discussions on this report.

10.4 The First Line Leadership training was evaluating well, Ms Wilkinson reported, and although it was only a pilot, it was well-developed. It was designed around personal impact and learning as well as leading with care. It would move from being self-nominating to a targeted approach.

10.5 On pensions taxation, Ms Wilkinson said that recommendations would be considered after the close of the national consultation on 1 November. Mr Stiff asked about the local

implications and Dr Johnson said that staff were awaiting the outcome of the consultation, which may not satisfy them. Mrs Schofield said that there had been no direct impact to date.

10.6 Ms Robson asked whether appraisal rates would hit the target and Ms Wilkinson replied that it was unlikely. She said it was a blend of a number of different factors. Mr Alldred said that it was a rolling, 12-month process and that the importance of appraisal had been stressed. Some areas were at 100% and others at 20-30% completion. Dr Johnson said that it was down to leadership whilst Mrs Schofield said that there was room for improvement and asked where progress was reviewed. Mr Russell said this was the task of the Senior Management Team and it was important to avoid a tactical approach. It was a cultural issue and Ms Wilkinson would to lead reflection and a reframing.

10.7 Mrs Taylor asked where the responsibility for job plans lay and Mr Alldred replied that this was with the Directorates. He suggested that the completion rate was around 80%.

ACTION: Ms Wilkinson to reflect on appraisal strategy and consider possible future restructuring and timescales.

11.0 Summary from the Quality Committee meeting of 4 September 2019

11.1 Ms Robson said that the Committee had received full assurance that the Duty of Candour was being complied with fully. However, there was poor compliance with closure of CAS alerts. Mr Harrison said that the performance in this area had decreased and that work was needed to understand why this had occurred. The outcome would be reported to the Operational Delivery Group.

12.0 Digital Strategy 2019-2024

12.1 The strategy had been circulated in advance of the meeting and it was taken as read.

12.2 Mrs Schofield said that Board members had received an excellent and detailed briefing. Mr Harrison said that the strategy covered the whole organisation, and included both patients and staff. It had been subject to wide consultation amongst clinicians and other staff and had been widely supported.

12.3 Ms Robson asked about the integration of HARA and Mr Harrison said that there were new laptops and information-sharing arrangements in place.

12.4 Mrs Schofield said that funding requirements would be subject to the usual processes and consideration at the time. The Board approved the Strategy.

APPROVED: The Board approved the Digital Strategy 2019-2024

To work with partners to deliver integrated care

13.0 West Yorkshire and Harrogate Partnership

13.1 Mrs Schofield noted that she was now the Vice Chairman of what was a very big meeting. A draft five-year plan, derived from the national 10-year plan had been presented but it was a long, formulaic and incomprehensible document so a revised version would be produced. There would be a summary for the Board drawing out the key issues and HDFT's contribution to them. In response to a question from Mr Thompson, Mr Russell

said that there were some programmes in the draft plan but that the governance had not yet been established.

Governance

14.0 Review of Third Party Schedule

14.1 The Schedule had been circulated in advance and was taken as read. The Board approved it subject to the addition of the Health Safety Investigations Board and the West Yorkshire and Harrogate Integrated Care System at the appropriate points.

APPROVED: The Board approved the Third Party Schedule subject to the listed amendments.

15.0 Harrogate Integrated Facilities (HIF) – Board Composition

15.1 Mrs Schofield noted the conflict of interest of Mr Coulter and Mr Thompson and indicated that they would be invited to contribute where appropriate.

15.2 Mr Harrison introduced the paper and gave some background details. The Board's original proposals had not been translated into the Reserved Powers, including around setting a maximum number of HIF Board members. The HIF Board had appointed the Managing Director as a Board member because there was no legal maximum. The proposal was to change the Articles of Association and establish a maximum number of seven Directors. The Trust appoints the Chairman but he or she is independent of the Trust. The balance between Trust-appointed Directors and HIF-appointed Directors would be maintained.

15.3 The proposal was to change the number of Directors to a maximum of seven with three appointed by the Trust (the Shareholder) and three appointed by HIF (the Company). This would satisfy the legal TEKAL requirements and maintains independence. The Trust would need to appoint a third Director.

15.4. Mrs Webster noted the original intention of the Board about the position of the Managing Director and that this would mean additional cost for both the Trust and HIF. Mr Harrison said that the Trust was seeking to accept the change but also to establish a clear maximum number of Directors. The delivery and quality of services was important and the HIF Board was financially-dominated at present.

15.5 Mrs Schofield said that HIF had taken the decision in good faith and that the Trust processes had not been fully joined up. She supported the principle of asserting the independence of HIF. Mr Thompson said that the logic of the change had been discussed at the HIF Board but he asked that further discussion of the matter be deferred to the private meeting. The Board agreed this.

16.0 Board of Directors Standing Order Review

16.1 The draft Standing Orders had been circulated in advance of the Board meeting and were taken as read. The draft contained minor changes and was approved.

APPROVED: The Board of Directors approved the revised Standing Orders.

17.0 Summary from the Audit Committee meeting of 11 September 2019
17.1 The paper had been circulated in advance of the meeting and was taken as read. Mr Thompson drew attention to the item on evening security. He said that whilst the Audit Committee had been alerted to issues by the report of the security inspection, which it had taken seriously, it had now remitted the matter to the Providing a Safe Environment Group, which reported to the Senior Management Team. He noted, however, that there had been no improvement between the last inspection and the most recent one. Mr Russell agreed to provide an update on security after the November Senior Management Team meeting. 17.2 Mr Thompson was pleased to report significant improvements in post-project evaluation reports and whilst there would need to be monitoring, they were clearly being taken more seriously. On the evaluation of the Trust's external auditors, he had asked for the survey to be re-run following issues which had been raised around finalisation of the Trust accounts this year.
ACTION: Mr Russell to provide an update on evening security to November meeting.
18.0 Minutes of the Council of Governors' Meeting of 1 May 2019
18.1 The Minutes were received by the Board.
19.0 Amendment to the Trust Constitution – Change of Title to Lead Governor
19.1 The proposed amendments had been circulated in advance and were approved by the Board.
APPROVED: The proposed amendments were approved by the Board.
20.0 Any other relevant business not included on the Agenda
There was no other business not included on the Agenda.
21.0 Board Evaluation
Board members agreed with Mrs Taylor that the patient story had been time well spent and Mrs Webster added that the item on Learning Disabilities and Learning from Deaths had been interesting. Mr Thompson said that the Board was growing better at scrutinising the IBR and Mrs Schofield said that the Board should periodically check every item; Mr Harrison said some were not materially different from month to month.
22.0 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 12.35pm.

Harrogate and District NHS Foundation Trust

HDFT Board of Directors Actions Schedule
Action Log
November 2019

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
81	January 2018	Further consideration to include additional metrics, change of style, inclusion of issues around AIC and patient experience in adult and children community services	Mr Harrison, Chief Operating Officer / Mr Alldred, Clinical Director LTUC / Dr Lyth, Clinical Director CCWCC	**November** 2019	
130	January 2019 (minute 17.2)	Post Project Evaluation of Supported Discharge Service to be considered by Board of Directors	Mr Harrison, Chief Operating Officer	November 2019	
136	May 2019 (minute 5.11)	Programme discussion of implications of CCG merger at future Board workshop	Mr Forsyth, Interim Company Secretary	September 2019	Programmed for October workshop
147	July 2019 (minute 6.4)	Bring forward proposals to Quality Committee and the Board of Directors around End of Life pathways and assessment of Respect and Trust policies, and gaps	Dr Scullion, Medical Director	January 2020	Action moved to Private Board agenda
148	September 2019 (minute 9.6)	Overview of Trust Learning Disabilities policies and application	Mrs Foster, Chief Nurse	October 2019	Discussion at October workshop
149	September 2019 (minute 10.7)	Reflect on appraisal strategy and consider possible future restructuring and timescales	Ms Wilkinson, Director W&OD	November 2019	
150	September 2019 (minute 17.2)	Update on evening security issues	Mr Russell, Chief Executive	November 2019	

You matter most

Harrogate and District NHS Foundation Trust

Date of Meeting:	27 November 2019	**Agenda item:**	5.0
Report to:	Board of Directors		
Title:	Report by the Chief Executive		
Sponsoring Director:	Mr Steve Russell, Chief Executive		
Author(s):	Mr Steve Russell, Chief Executive		
Report Purpose:	**Decision**		**Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓
Executive Summary:	• The Trust delivered a surplus in October but is £0.2m behind plan at month 7 • Recovery plans are in place but contain risk, especially at this time of year • Emergency Department admissions were 10% above plan and, as a consequence, performance in October was 90.4% against the 95% standard, although this was the best in the West Yorkshire and Harrogate ICS • Peer vaccinators are working hard on the flu vaccination campaign • A business case for phase two of the Ambulatory Care Unit has been developed for approval by the Board • The Trust's end of life support volunteers were awarded Volunteer Team of the Year at the Harrogate and District Volunteering Oscars		

Related Trust Objectives					
To deliver high quality care	✓	**To work with partners to deliver integrated care:**	✓	**To ensure clinical and financial sustainability:**	✓

Key implications	
Risk Assessment:	None identified
Legal / regulatory:	None directly identified.
Resource:	The document outlines the financial challenges the Trust is currently managing.
Impact Assessment:	Not required
Conflicts of Interest:	None identified
Reference documents:	Not applicable

Action Required by the Board of Directors:
The Board of Directors is asked to **note** and **comment on** the contents of this report

6

Chief Executive's Report – November 2019

2019/20 Operational and financial performance

1. As is detailed within the reports from Executive Director colleagues, the operational and financial position is particularly challenging at the present time.

2. Financially, whilst delivering a surplus in October, we are now £0.2m behind our financial plan as at the end of October. There have been detailed discussions across the Trust over the last two months with a focus on the following areas:

    a. Reducing the expenditure run-rate of operational directorates by reducing premium spend and reducing planned investment in Winter resilience by a total of £1.2m.
    b. Ensuring Harrogate Integrated Facilities (HIF) delivers its financial plan of a £200k surplus.
    c. Securing income of £1.5m to support the costs being incurred as a consequence of both emergency and elective activity patterns.

3. Whilst progress has been made in a number of areas, and there are recovery plans which reduce the forecast expenditure variance to £0.4m, these contain risk, particularly given the time of year, and this work continues to be a significant focus for Directorate and Corporate teams.

4. At this stage we continue to forecast that we will deliver our control total, but will continue to review the risks to this. Board colleagues will recall that the plan set for 19/20 was particularly challenging given non-recurrent actions in 18/19 and additional pressures which have arisen during the year such as the costs of supporting the UCI world cycling, the cost of NHS Property Services from prior years, and the medical pay award being c£0.4m higher than the funding provided (despite it being due to be cost neutral to providers)

5. In terms of performance it has been a challenging two months within the Emergency department, which is a barometer of the pressure on services and people across HDFT as a whole – both in the hospital and importantly in our community services. Activity continues to be higher than plan, most notably in emergency admissions which are 10% higher than plan.

6. As a consequence of this, our delivery of the four-hour standard has fallen to 90.4% for the month of October and work is being progressed with the teams involved to improve performance. It should be noted that we remain one of the better performers regionally and nationally, such is the pressure across the country. National performance was 83.9%, and HDFT was the highest performing Trust in West Yorkshire & Harrogate ICS in October.

Winter

7. We have recently received correspondence from NHS England & NHS Improvement (NHSE/I) in respect of winter preparations. Six areas were highlighted for organisations, namely:

   - More hospital beds to be open
   - Work with local authorities to ensure additional care packages and additional nursing and residential home beds are available
   - Ensure resilience of GP out of hours services
   - Ensure mental health services respond quickly when required
   - Ensure community services respond with the same 'clock speed' as acute services
   - Increase the uptake of the flu vaccine

8. We are working through these areas with the A&E delivery board, and whilst the biggest capacity risk is workforce, 19/20 has not seen any additional funding made available for Winter which poses a key risk in the areas where additional capacity could be needed. We have assessed our position and are preparing a position statement from the system to be communicated back to NHSE/I as requested.

9. We have 65 peer vaccinators across all our clinical areas, who are working incredibly hard to support, lead and promote the flu vaccine. Overall uptake is 49%, with 50% in corporate areas, 35% in HIF, 39% in 4C's, 58% in LTUC and 54% in PSC.

Pensions

10. Within the winter correspondence, Trusts were encouraged to make use of the flexibility to pay employer pension contributions to doctors who leave the pension scheme to encourage an increase in clinical capacity over winter. This issue has already been considered by the Trust, and other Trusts in WYAAT and no changes prior to the outcome of the national consultation.

11. Subsequently, NHS England and NHS Improvement have announced a scheme which proposes to effectively pay the tax liability for clinicians who incur this as a result of NHS activity causing them to breach the annual allowance. There are a number of risks associated with this, and we are awaiting further guidance.

Medium Term Financial Sustainability

12. This work continues to progress well, with a jointly agreed understanding across the Trust and CCG of the underlying drivers of the financial deficit which can be summarised as:

- We have a significantly older population
- The nature of the population means that they access care readily
- The allocation formula does not adequately reflect the needs of the population
- We have a care model that is dependent on hospital bed occupancy
- There are areas where provision could be delivered more efficiently
- There are some sub-scale specialties that require a network approach to ensure financial and clinical resilience

13. Given this, the next phase of the work is focused on developing a clinical vision across the Harrogate place, in particular for older people, linking this work to the development of the Primary Care Networks in the area and assessing the options in respect of maternity and paediatric services, and surgical services.

14. We intend to produce a high level strategic plan which will describe the changes that need to be made, when they will be made and the impact over a 5 year plus period.

Capital

15. We have undertaken a review of our capital programme to prioritise the capital resource that is available for the remainder of the year. Following discussion at SMT and Resources Committee, we have agreed to progress with the phase two of the Ambulatory Care Unit. A business case has been developed for consideration and the plan is for the scheme to begin shortly, subject to approval.

16. NHSE/I recently announced that funding was available for diagnostic equipment that was over 10 years old and required replacing. Funding is available over a two year period, and we have been identified to benefit from additional resource in respect of our mammography equipment which is over 10 years old. We are in discussion with NHSE/I in respect of the business case and procurement requirements, and anticipate that the scheme could during the next calendar year.

Briary Wing

17. For some time it has been the intention of Tees, Esk & Wear Valley to withdraw services from the Briary Wing as alternative models of care are developed that do

not require the Briary Wing facilities. We have been formally informed that TEWV will vacate the facility at the end of May 2020 and we are working with them to ensure an orderly transition.

18. The use of this vacated space is part of the Site Strategy work that is being led by the Deputy Chief Executive.

North Yorkshire CCG

19. NHS England has approved the merger of Harrogate & Rural District, Hambleton, Richmond & Whitby and Scarborough & Ryedale CCGs to form North Yorkshire CCG from 1st April 2020.

20. We look forward to working with Amanda Bloor and her team to ensure a successful transition and to continuing to work with her team to ensure the new arrangements benefit the population of North Yorkshire, whilst retaining a strong focus on Harrogate as a place.

21. There are an important set of considerations that arise from this transition, particularly in respect of the Trust's place within ICSs and other partnerships, as the new CCG will span two ICSs.

Senior Management team (SMT)

22. At its most recent meeting, SMT's discussion was focussed on:

- The financial position and recovery plans
- Clinical management of head injuries and future clinical management of NIV patients
- The flu vaccination campaign
- Delivering the CQC action plan
- The business case to develop a CT suite
- The North Yorkshire 0-19 service

There was also an update presented in respect of the Care after Death RPIW.

23. As part of our teamHDFT 'people plan' we are creating a 'shadow SMT' which will offer the opportunity to bring more lenses and perspectives into our decision making. This is supported by a development programme for participants and is due to start in January 2020.

Some things to celebrate….

24. Harrogate Hospital & Community Charity has launched its first ever fundraising calendar, made up of winning photos submitted by local people following a photography competition from across the areas where the Trust provides services: North Yorkshire, Leeds and the North East. Other categories include Communities, Excellence Every Time, Healthcare, Pride and #teamHDFT (kindness, compassion, teamwork and friendship). Thanks are due to Harrogate Harlow, a private healthcare provider based at Harrogate District Hospital, for their sponsorship.

25. The Trust's Organ Donation Committee has unveiled two wall mounts in honour of members of our community who have been touched by organ donation. They feature Gavin, who donated his organs following an accident two years ago, and Mark – who received a kidney and pancreas transplant, showing the different sides to organ donation. Gavin's inspirational family, alongside Mark, recently visited the wall mounts.

26. Harrogate Integrated Facilities have introduced the 'HIF Hero' award. These are new monthly awards based on people nominated who have been felt to go above and beyond in their daily duties. The first winner of the award was Angie Olbison.

27. We were delighted to hear that our end of life support volunteers were awarded Volunteer Team of the Year at the Harrogate and District Volunteering Oscars. We'd like to say a huge thank you to them and all our volunteers who give up their time to support our patients and staff.

Licences signed

28. Since the September meeting of the Board of Directors the following documents have been signed and sealed:

- Two Licences with NHS Property Services for alterations at Ripon Hospital and Fysche Hall, Knaresborough.
- A Deed of Variation to the contract for the provision of the 0-19 Healthy Child Service for Stockton-on-Tees
- A Deed of Variation for the provision of the Growing Well, Growing Healthy service for Stockton-on-Tees
- A Deed of Variation of a Lease in connection with a Reversionary Lease (Lingfield Pt no 1)

We also signed recently a renewal of our Licence to Occupy clinics at Silver Birches in Filey in respect of Podiatry until 31 December 2020.

Risks

Corporate Risk Register Summary

29. The Corporate Risk Register was reviewed at the Corporate Risk Review Group meeting on 8 November. No new risks were added and there were minor changes to the existing risks, mainly around progress scores, as shown in the following table.

Corporate risk register summary of changes: Updated October 2019

Ref	Description	Current risk score	Risk movement	Current progress score	Target date for risk reduction	Notes
CR2	Risk to the quality of service delivery in Medicine due to gaps in rotas; reduction in trainee numbers; agency cap rate; quality control of locums; and no-deal EU Exit *(added 08/03/2019)*.	12	↓	*3*	*Mar-20*	*Risk reduced to reflect directorate risks*
CR5	Risk to the quality of service delivery and patient care due to failure to fill registered nurse, ODP and health visitor vacancies due to the national labour market shortage and local shortages in some areas e.g. Stockton.	12	↔	*2*	*Oct-20*	
CR14	Risk of financial deficit and impact on the quality of service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income. *NB Impact of no-deal EU Exit on annual financial plan added 08/03/2019*	12	↔	*2*	*Mar-20*	
CR18	Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down	12	↔	*1*	*Aug-20*	
CR26	Risk of inadequate antenatal care and patients being lost to follow up - due to inconsistent process for monitoring attendance at routine antenatal appointments in community	12	↔	*2*	*Oct-19*	
CR32	Financial risk from major sporting events due to cost of contingency arrangements and loss of income	12	↔	*3*	*Sep-19*	*To be reviewed and updated*
CR34	Risk to quality of care by not meeting NICE guidance in relation to the completion of autism assessment within 3 months of referral.	12	↔	*1*	*Mar-20*	
CR41	CR41 Summary RTT risk - Risk to patient safety, performance, financial performance and reputation due to increasing waiting times across a number of specialties	12	↔	*tbc*	*tbc*	*Work to be done to define risk mitigation, gaps and target date for risk reduction*
CR42	Risk that staff are not able to access IT systems due to Cyber Security attacks or issues with the WIFI network	12	↔	*3*	*Jan-20*	
CR43	Pharmacy & Pathology Walk in Fridges. Recurring issue, was originally PH 109. Risk of financial loss of wasted stock and potential delays in treatment due to failure to maintain temperatures in Pharmacy walk-in fridges due to age of compressors.	12	↔	*5*	*Jan-21*	

Progress key

1 = fully on plan across all actions
2 = actions defined - most progressing, where there are delays, interventions are being taken
3 = actions defined - work started but behind plan
4 = actions defined but largely behind plan
5 = actions not yet fully defined

Board Assurance Framework Summary

The summary of strategic risks to the Trust, as reflected in the Board Assurance Framework, is unchanged as follows:

Ref	Description	Risk score	Progress score	Target risk score reached
BAF 1	Risk of a lack of medical, nursing and clinical staff	*Amber 9* ↔	*Unchanged at 1*	√
BAF 2	Risk of a high level of frailty in the local population	*Amber 8* ↔	*Unchanged at 1*	√
BAF 3	Risk of a failure to learn from feedback and Incidents	*Amber 9* ↔	*Unchanged at 2*	
BAF 5	Risk of maintaining service sustainability	*Amber 9* ↔	*Unchanged at 1*	
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	*Yellow 5* ↔	*Unchanged at 1*	√
BAF 12	Risk of external funding constraints	*Red 12* ↔	*Unchanged at 1*	√
BAF 13	Risk standards of care and the organisation's reputation for quality fall because quality does not have a sufficient priority in the Trust	*Yellow 4* ↔	*Unchanged at 1*	√
BAF 14	Risk of delivery of integrated models of care	*Amber 8* ↔	*Unchanged at 1*	√
BAF 15	Risk of misalignment of strategic plans	*Red 12* ↔	*Unchanged at 1*	
BAF 16	Risk that the Trust's critical infrastructure (including estates, diagnostic capacity, bed capacity and IT) is not fit for purpose	*Red 12* ↔	*Improved to 2*	
BAF 17	Risk to senior leadership capacity	*Amber 8* ↔	*Unchanged at 1*	

Steve Russell **25 November 2019**
Chief Executive

Harrogate and District NHS Foundation Trust

Integrated board report - October 2019

Key points this month

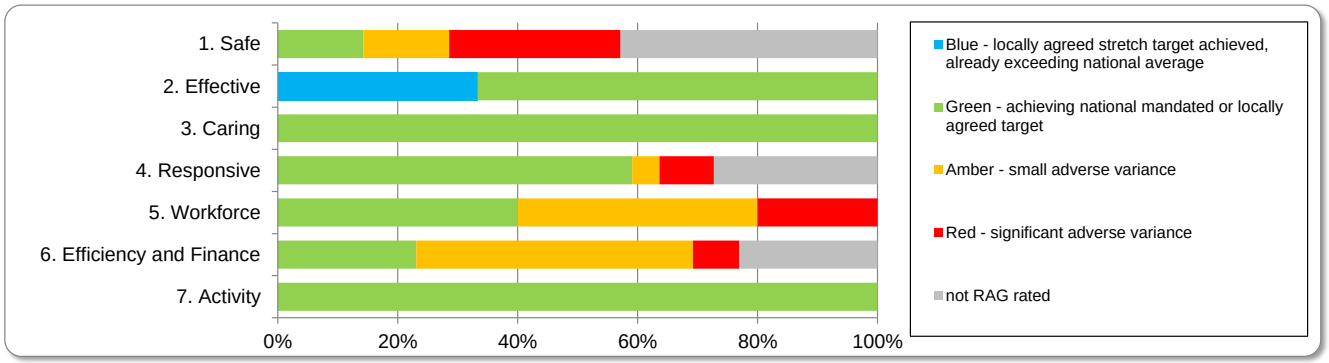
1. For the first time in 2019/20 the Trust reported an adverse position to plan in October. In month performance was a £674k surplus, £329k behind plan. This adverse position results in the year to date deficit being £1,712k, £217k behind plan

2. HDFT's performance against the A&E 4-hour standard was below 95% in October (90.4%), a deterioration on last month (94.0%)

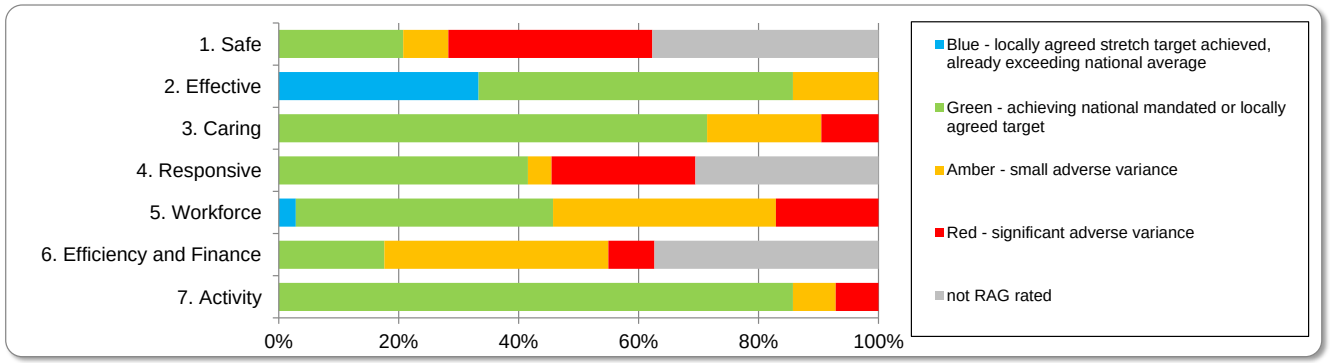
3. RTT - total number of waiters at month-end was 15,856. This is above our agreed trajectory of 15,750.

4. Provisional data indicates that 6 of the 7 applicable cancer waiting times standards were achieved in October, with Screening performance below the operational standard at 70% (further details contained in this report).

Summary of indicators - current month

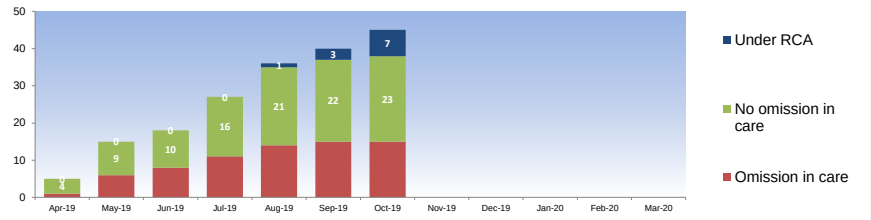
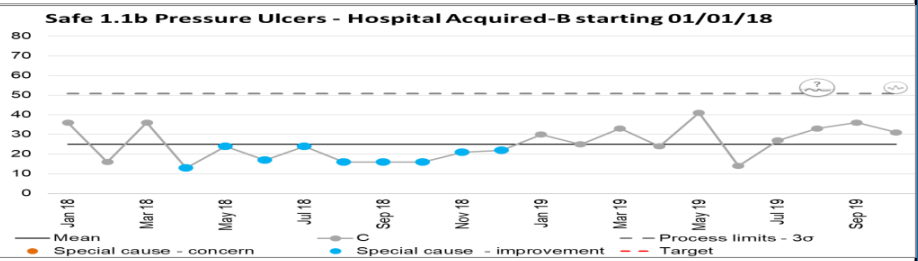
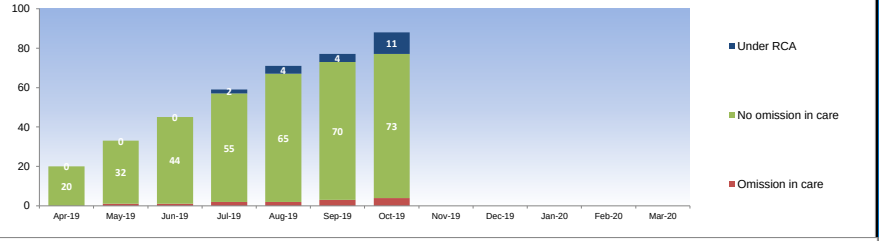
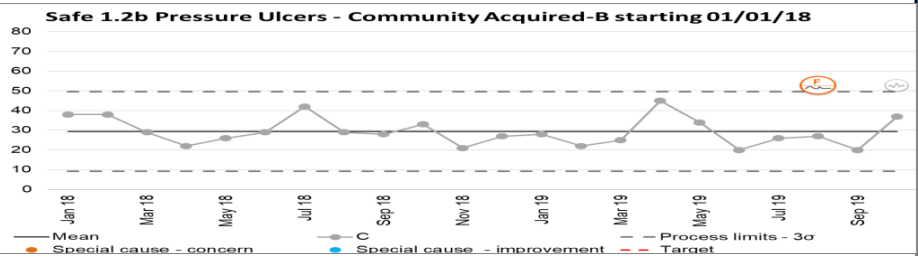


Summary of indicators - year to date

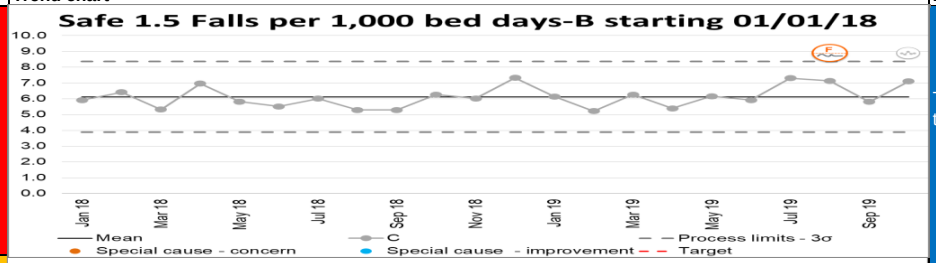
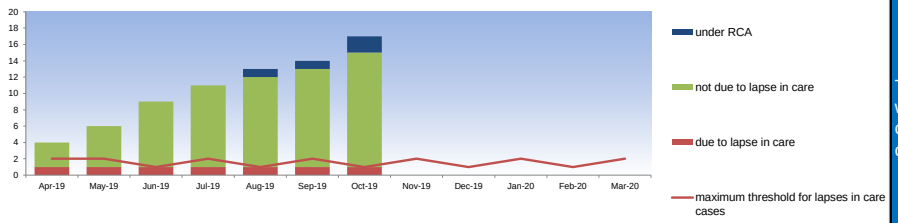
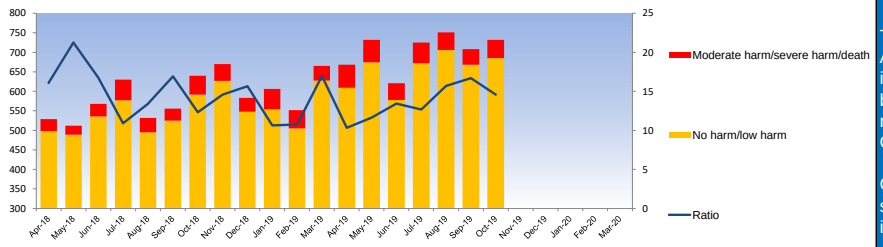
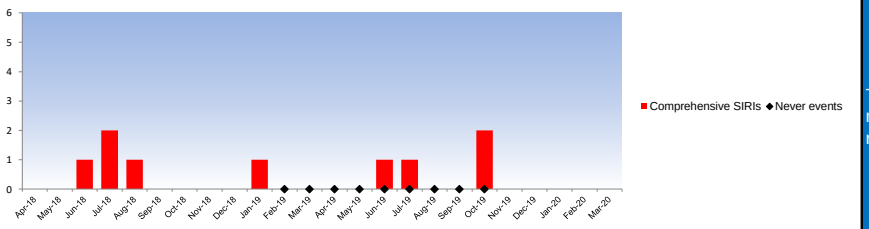


Harrogate and District NHS Foundation Trust

Section 1 - Safe - October 2019

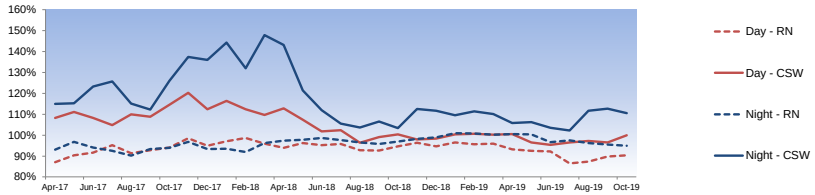
Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.1a	Pressure ulcers - hospital acquired		There were 5 hospital acquired category 3 and above pressure ulcers reported in October (including device related and device related mucosal). This is lower than last year with an average of 6 per month reported in 2018/19. Of the 5 reported there were 0 omission in care, 1 no omission in care and 4 under RCA.
1.1b			The number of hospital acquired category 2 and above pressure ulcers reported in October was 31. The reported number is inclusive of device related and device related mucosal pressure ulcers.
1.2a	Pressure ulcers - community acquired		There were 11 community acquired category 3 and above pressure ulcers reported in October (including device related and device related mucosal). The average per month reported in 2018/19 was 11. Of the 11 reported there were 7 under RCA, 1 ommision in care and 3 no ommission in care.
1.2b			The number of community acquired category 2 and above pressure ulcers reported in October was 37. The number reported is inclusive of device related and device related mucolsal pressure ulcers.

Section 1 - Safe - October 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.3	Falls		The rate of inpatient falls was 7.12 per 1,000 bed days in October. This is higher than the average HDFT rate for 2018/19 (6.01)
1.4	Infection control		There were 3 cases of hospital apportioned C. difficile reported in October 2 of which were not due to a lapse in care and one of which is under RCA. No MRSA cases have been reported in 19/20. The annual maximum threshold for lapses in care cases for 2019/20 is 19.
1.5	Incidents - all		The latest published national data (for the period Apr 18 - Sept 18) shows that Acute Trusts reported an average ratio of 46 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's published ratio was 22, an increase on the last publication but remaining in the bottom 25% of Trusts nationally. HDFT's latest local data for October gives a ratio of 14 a slight decrease on the September position of 16. CCCC is continuing to focus on its reporting culture. There are now 4 DATIX super-users and a focus on reporting and learning. CCCC is showing improvements in its reporting culture and there is a focus on response rates.
1.6	Incidents - SIRIs and never events		There was one comprehensive SIRI in June, one in July and two in October but no Never Events were reported for the year-to-date. No Never Events were reported in 2017/18 or 2018/19.

Harrogate and District NHS Foundation Trust

Section 1 - Safe - October 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.7	**Safer staffing levels** DQ		In October staff fill rates were reported as follows: Registered Nurses Day 90.4% and Night 95.0%, Care Staff Day 100.0% and Night 110.5%. Reported care hours per day per patient was 8.00 hours per day.

Harrogate and District NHS Foundation Trust

Section 1 - Safe - October 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Safer staffing

The table below summarises the average fill rate on each ward during October 2019. 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 "Care Hours per Patient Day" (CHPPD) metric. Our overall CHPPD for October was 8.0 care hours per patient per day.

October 2019							
	% Fill Rate				Care hours per patient day		
	Day		Night				
Ward Name	RN	CSW	RN	Care Staff	RN	CSW	Overall
Byland	85.6%	98.0%	80.0%	125.3%	2.50	3.60	6.10
Farndale	91.4%	97.3%	100.0%	100.0%	3.10	3.90	6.90
Granby	99.0%	128.2%	100.0%	100.0%	3.30	3.30	6.70
Harlow	106.5%	100.0%	100.0%	-	7.10	2.00	9.10
ITU/HDU	84.0%	-	92.9%	-	25.50	2.30	27.90
Jervaulx	89.0%	102.6%	80.0%	126.9%	2.50	3.60	6.10
Lascelles	103.4%	89.7%	100.0%	100.0%	5.30	4.40	9.70
Littondale	92.8%	99.5%	97.8%	103.2%	4.10	2.50	6.60
Maternity	95.7%	72.6%	93.3%	93.5%	4.90	3.10	8.00
Medical Assessment Unit	88.7%	104.8%	98.8%	103.2%	4.40	2.70	7.10
Medical Short Stay	97.7%	96.3%	98.4%	102.2%	3.70	2.90	6.50
Nidderdale	94.7%	113.4%	94.6%	180.6%	3.40	3.80	7.30
Oakdale	80.8%	92.7%	98.9%	109.7%	7.40	2.60	9.90
Special Care Baby Unit	78.1%	41.9%	83.9%	-	3.60	4.10	7.80
Trinity	96.4%	97.4%	98.4%	100.0%	3.40	2.50	5.80
Wensleydale	86.7%	108.9%	101.6%	109.7%	8.50	2.60	11.10
Woodlands	77.7%	95.2%	97.8%	87.1%	18.70	4.90	23.60
Total	**90.4%**	**100.0%**	**95.0%**	**110.5%**	**4.80**	**3.30**	**8.00**

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Section 1 - Safe - October 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Further information to support the October safer staffing data

On the wards: Byland, Jervaulx, MAU, Oakdale, Littondale and Wensleydale 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.

The planned staffing levels on Farndale ward were adjusted in October to reflect the closure of beds in this area in response to activity levels.

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.

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 Registered Midwife and care staff gaps were due to sickness in October; however a professional assessment was made on a shift by shift basis to ensure that nurse staffing numbers matched the activity.

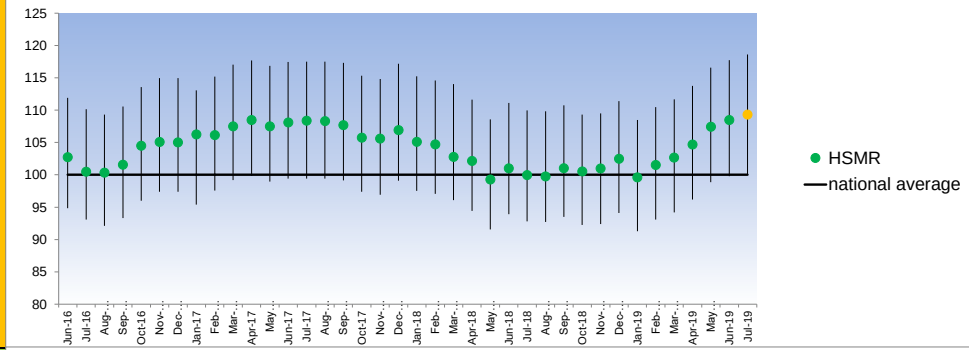
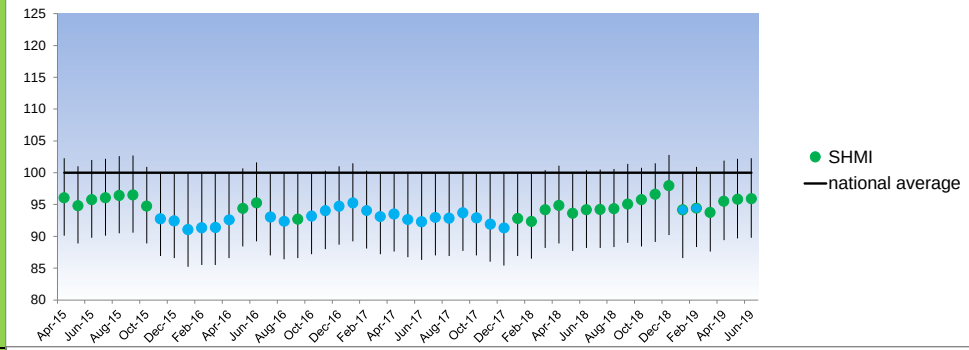
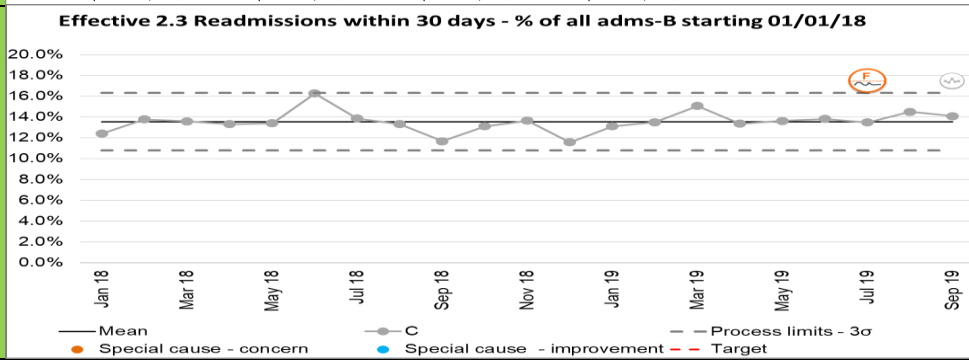
In some wards the actual care staff hours show additional hours used for enhanced care for those patients who require intensive support. In October this is reflected on the wards; Byland, Jervaulx, Oakdale, Granby, Wensleydale and Nidderdale.

For the Special Care Baby Unit (SCBU) although the day and night time RN and daytime care staff hours appear as less than planned in October, 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 Woodlands ward the day and night time RN and care staff hours are less than 100% in October, however 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.

Harrogate and District NHS Foundation Trust

Section 2 - Effective - October 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
2.1	Mortality - HSMR (DQ)		HDFT's HSMR has increased to 109.31 for the rolling 12 months ending July 2019 . Three specialties have a higher than expected standardised mortality rate: Anaesthetics, Geriatric Medicine and General Medicine. We are analysing the data with HED and auditing the notes of affected specialties / diagnostic groups to understand the recent increase.
2.2	Mortality - SHMI (DQ)		HDFT's SHMI for the rolling 12 months ending June 2019 is 95.9, remaining below expected levels. At specialty level, five specialties (Trauma and Orthopaedics, Gastroenterlogy, Respiratory Medicine, Geriatric Medicine, and General Medicine) have a standardised mortality rate above expected levels.
2.3	Readmissions (DQ)		Emergency Readmissions decreased from 14.5% in August to 14.1% in September This is slightly above the 2018/19 average of 13.5%.

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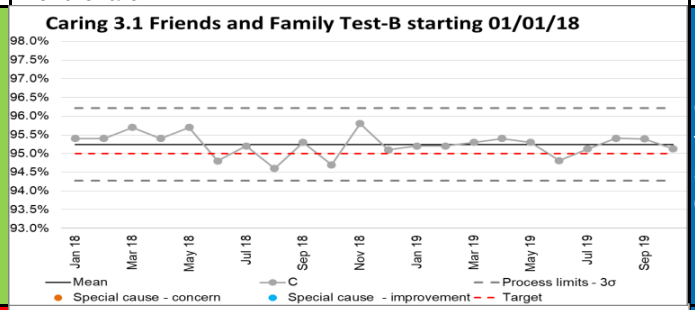
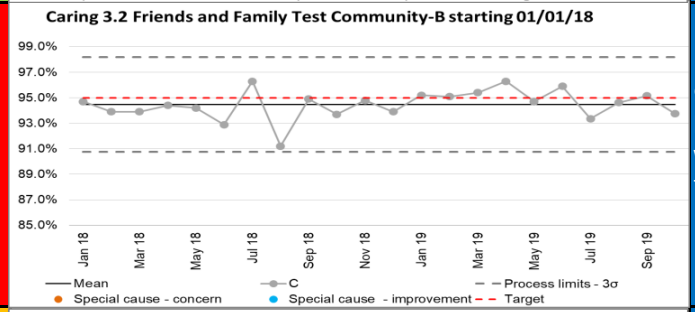
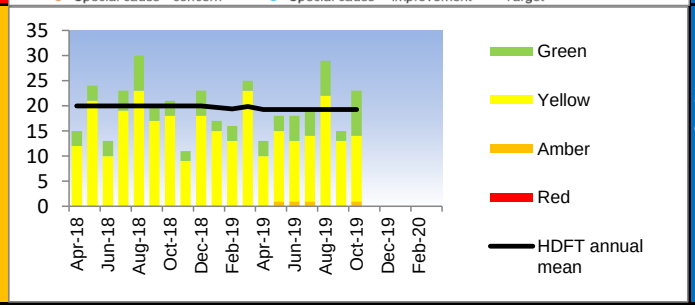
Section 3 - Caring - October 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
3.1	Friends & Family Test (FFT) - Patients DQ		95.1% of patients surveyed in October would recommend our services remaining above the latest published national average (93.6%). 5,542 patients responded to the survey this month of which 5,272 would recommend our services.
3.2	Friends & Family Test (FFT) - Adult community services DQ		93.8% of patients surveyed in October would recommend our services, a decrease on last month (96.2%). Current national data (March) shows 95% of patients surveyed would recommend the services. 416 patients from our community services responded to the survey this month of which 390 would recommend our services.
3.3	Complaints DQ		23 complaints were received in October which is 8 higher than September and just above the average for 2018/19 of 20. One of the complaints was classified as amber but none as red this month.

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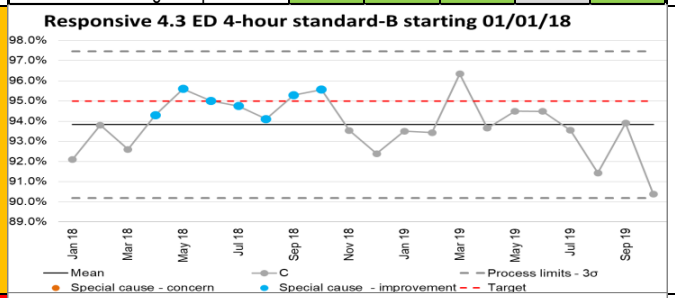
Section 4 - Responsive - October 2019

NHS Improvement Single Oversight Framework

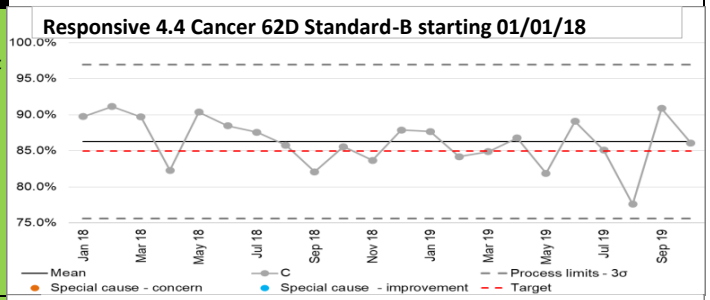
4.1 NHS Improvement Single Oversight Framework	Standard	Q1	Q2	Q3	Q4	YTD
	RTT incomplete pathways					
	A&E 4-hour standard	94.2%	92.8%	90.4%		93.1%
	Cancer - 62 days	85.5%	84.5%	87.6%		85.4%
	Diagnostic waits	99.4%	98.96%	98.7%		99.1%
	Dementia screening - Step 1	93.4%	94.7%	90.9%		93.5%
	Dementia screening - Step 2	96.6%	100.0%	100.0%		98.7%
	Dementia screening - Step 3	100.0%	100.0%	100.0%		100.0%

4.2 RTT Incomplete pathways performance — DQ

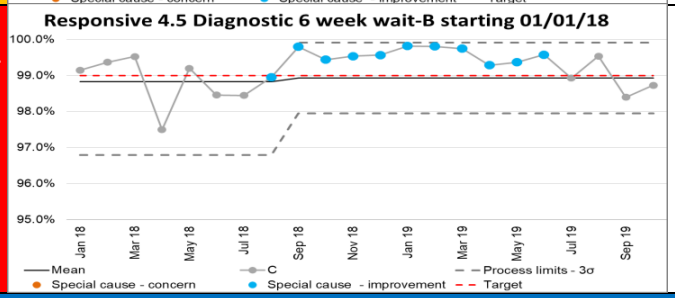
4.3 A&E 4 hour standard — DQ



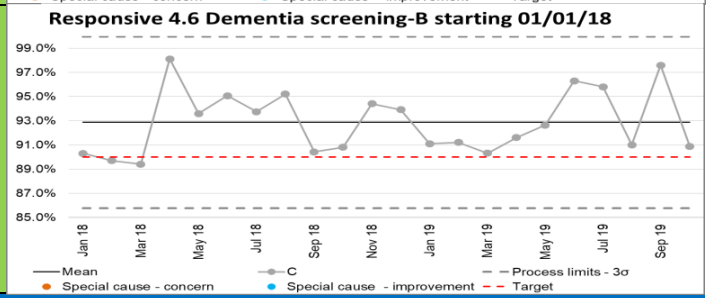
4.4 Cancer - 62 day wait for first treatment from urgent GP referral to treatment — DQ



4.5 Diagnostic waiting times - 6-week standard — DQ



4.6 Dementia screening — DQ



Narrative

Performance against the 62 day cancer standard was delivered in October with provisional performance at 87.6% (see a more detailed summary below). Delivery of the 2WW breast symptomatic standard continued in October with performance at 98.7%, an improvement on last month (95.2%).

Diagnostic waiting times were not delivered in October with 98.7% of patients waiting less than 6 weeks at month end. This was primarily due to waits for Urodynamics.

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Section 4 - Responsive - October 2019

Cancer waiting times standards

4.7	Cancer - 14 days max wait from urgent GP referral for suspected cancer	DQ	Responsive 4.7 Cancer 14D Standard-B starting 01/01/18	4.8	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	D	Responsive 4.8 Cancer 14D Breast Sympton Standard-B starting 01/01/18
4.9	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	DQ	Responsive 4.9 Cancer 31D First Treatment-B starting 01/01/18	4.10	Cancer - 31 day wait for second or subsequent treatment: Surgery	DQ	Responsive 4.10 Cancer 31D Subsequent Surgery-B starting 01/01/18
4.11	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	DQ	Responsive 4.11 Cancer 31D Subsequent Drugs-B starting 01/01/18	4.12	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	DQ	Responsive 4.12 Cancer 62D Standard-B starting 01/01/18
4.13	Cancer - 62 day wait for first treatment from screening service	DQ	Responsive 4.13 Cancer 62D Screening-B starting 01/01/18	4.14	Cancer - 62 day wait for first treatment from consultant upgrade	DQ	Responsive 4.14 Cancer 62D Cons Upgrade-B starting 01/01/18

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Section 4 - Responsive - October 2019

Narrative

Provisional data indicates that 6 of the 7 applicable cancer waiting times standards were achieved in October, with Screening performance below the operational standard of 90% - 8 Bowel Screening patients were treated in the month (4 Leeds, 3 Harrogate, 1 York) and 4 of these received treatment after 62 days (3 Leeds, 1 Harrogate). These delays were due to pathway complexity and other clinical factors. Of the 4 patients treated at Leeds, 3 were transferred to Leeds by day 38, meaning that the total accountable Screening denominator was 5.0 with 1.5 patient treated after day 62 (70%).

Provisional data report that there were 56.5 accountable 62 day standard treatments in the month with 7.0 breaches, meaning performance was above the standard at 87.6%. Of the 11 tumour sites, 6 had performance below 85% in October - Breast (1 actual breach, 1.0 accountable), Head and Neck (1 actual breach, 1.0 accountable), Lung (2 actual breaches, 1.5 accountable), Upper GI (3 actual breaches, 1.5 accountable), and Other (2 actual breaches, 1.0 accountable). 4 patients waited over 104 days for treatment in October - these were due to a combination of pathway complexity, clinical suspension, patient choice/holiday, and elective capacity at Leeds.

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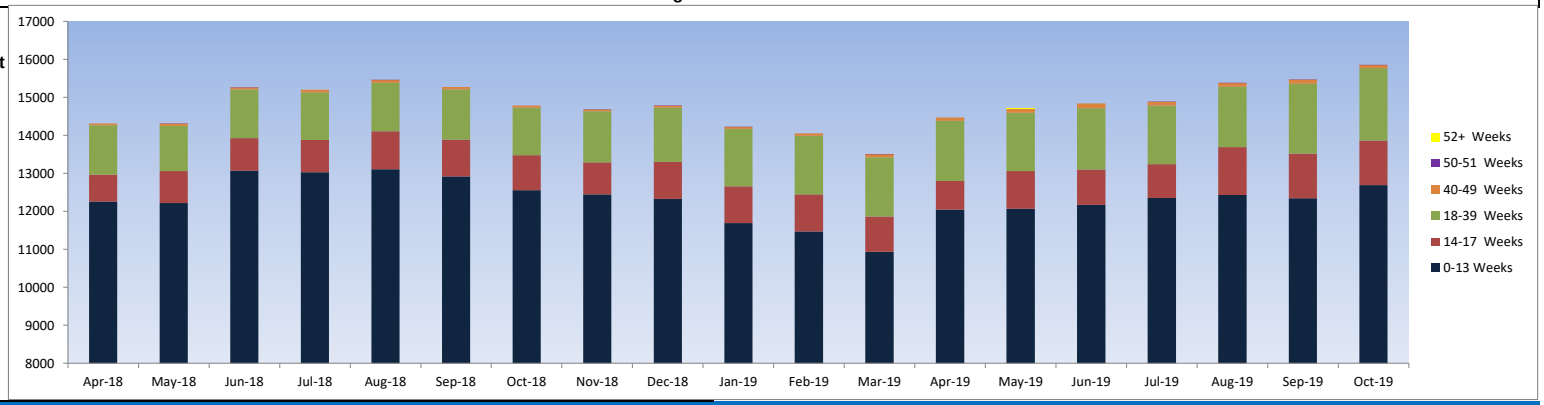
Section 4 - Responsive - October 2019

RTT waiting list metrics

4.15	RTT waiting list split by weeks	DQ



Narrative

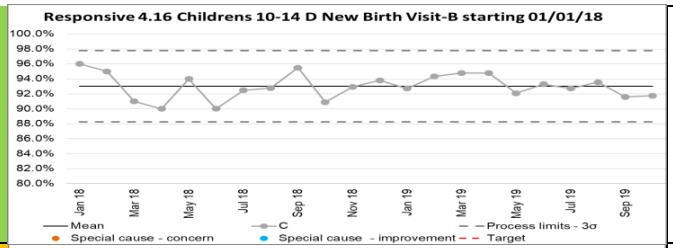
There were a total of 15,856 patients on the RTT waiting list at the end of October, this is 106 above our agreed trajectory of 15,750. Part of the increase (150) is a result of Dental patients now being included in our outturn position, the trajectory does not include dental patients. There were no patients waiting over 52 weeks at the end of the month.

NHS Harrogate and District NHS Foundation Trust

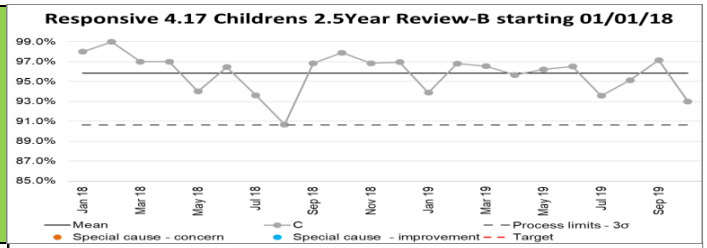
Section 4 - Responsive - October 2019

Children's Services metrics

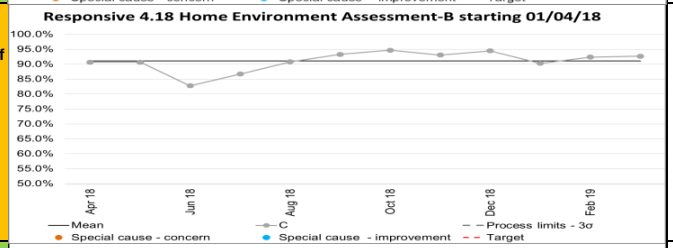
4.16 Children's Services - 10-14 day new birth visit — DQ



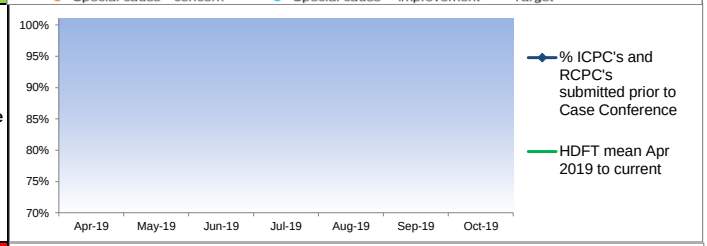
4.17 Children's Services - 2.5 year review — DQ



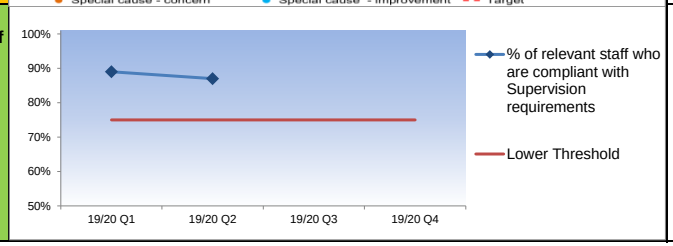
4.18 Children's Services - Use of the Home Environment Assessment Tool — DQ



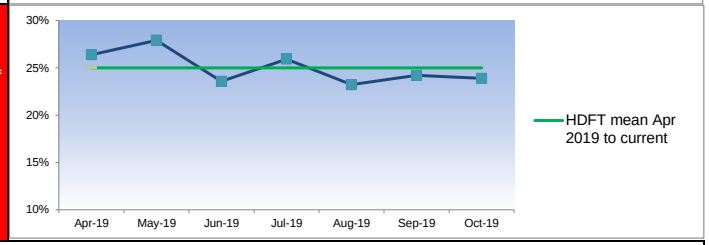
4.19 Children's Services - Reports for Initial and Review Child Protection Case Conferences — DQ



4.20 Children's Services - Staff compliance with Safeguarding Supervision. — DQ

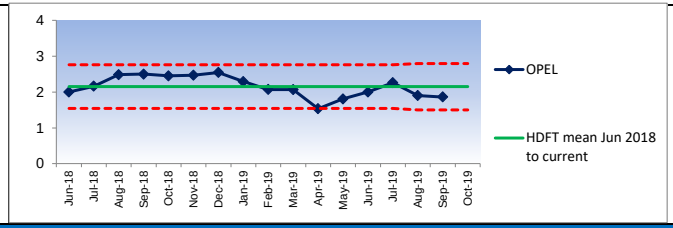


4.21 Children's Services - Reports for Achievement of KPI for Breast Feeding Prevalence. — DQ

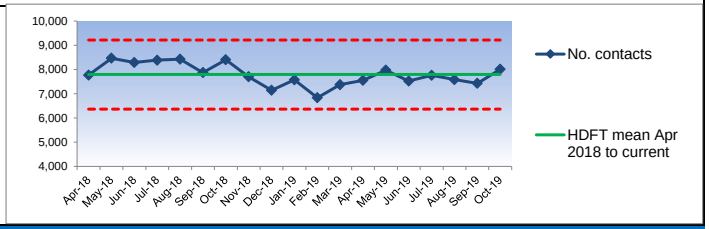


Adult Community Services metrics

4.22 OPEL level - Community Care Teams — DQ



4.23 Community Care Teams - patient contacts — DQ



Narrative

The Children's Services and Adult Community Services metrics are currently showing no adverse variance.

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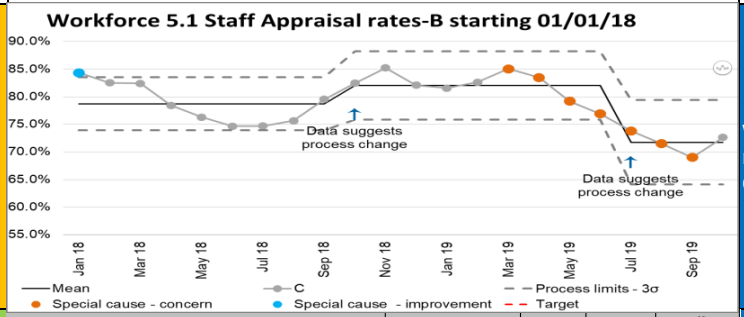
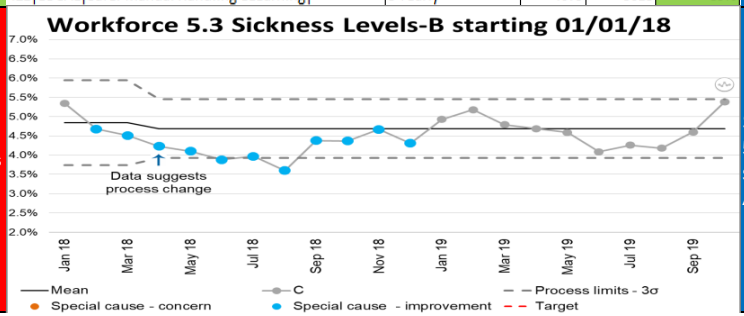
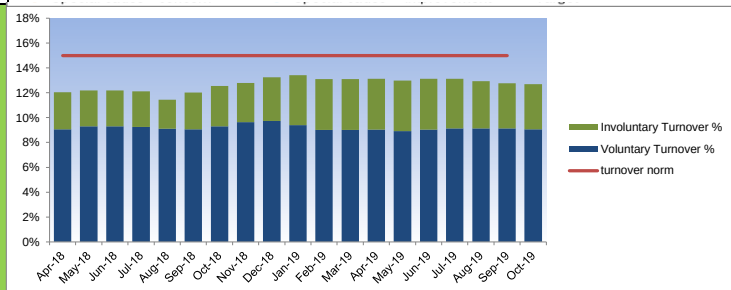
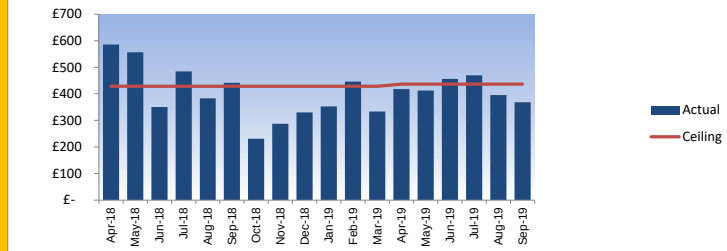
Section 5 - Workforce - October 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.1	Staff appraisal rates DQ		We are currently in the process of reviewing the appraisal window with respect to the response rate and the effectiveness of the paperwork attached to the appraisal (e.g. full documentation/appraisal on a page).
5.2	Mandatory training rates DQ	See table below	Mandatory % Report – Trust exc HIF 01.11.19 The data shown is for the end of October and excludes the Harrogate Integrated Facilities (HIF) staff who transferred into the new organisation on the 1st March 2018. The overall training rate for mandatory elements for substantive staff is 93% which is at the same level as the last reporting cycle.
5.3	Sickness rates DQ		Staff absence has increased considerably from in the last month reaching a Trust total of 5.38%. A number of interventions have been put in place to assist in the reduction of sickness absence, including absence masterclasses and a full review of the Managing Attendance and Promoting Health & Wellbeing policy.

Competence Name	Renewal Period	Required	Achieved	Compliance %
NHS|CSTF|Information Governance and Data Security - 1	Annual	4079	3754	92%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years	3 Yearly	4079	3789	93%
421|LOCAL|Fire Safety - Level 1|	Annual	4079	3571	88%
NHS|MAND|Infection Control - No Renewal|	Once Only	4079	4024	99%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3	3 Yearly	4079	3781	93%
421|LOCAL|Risk Awareness eLearning|	Once Only	4079	3950	97%
NHS|CSTF|Health, Safety and Welfare - 5 Years|	5 Yearly	4079	3957	97%
421|LOCAL|Safer Manual Handling eLearning|	3 Yearly	4079	3618	89%

Section 5 - Workforce - October 2019

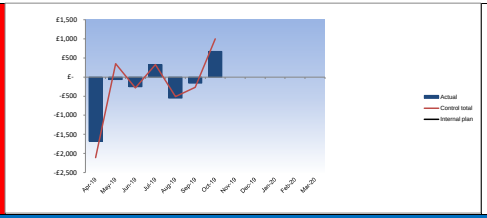
Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.4	Staff turnover rate DQ		Staff turnover is continuing to slowly reduce. A number of staff engagements are taking place including the review of 3 major HR Policies – Managing Attendance & Promoting Health &Wellbeing, Disciplinary and Grievance where staff have been invited to join the working groups to assist in the development of new policies and procedures. Active encouragement is taking place for staff to complete this year's Staff Survey and have their say.
5.5	Agency spend in relation to pay spend DQ		Agency expenditure remains a concern with a spike in expenditure reported in October. Overall the position remains below the agency ceiling.

NHS Harrogate and District NHS Foundation Trust

Section 6 - Efficiency and Finance - October 2019

Finance

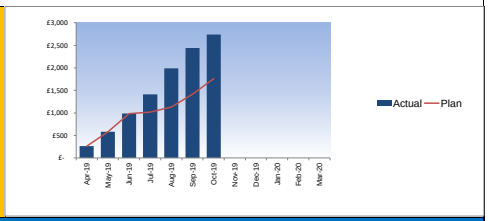
6.1 Surplus / deficit and variance to plan



6.2 NHS Improvement Single Oversight Framework - Use of Resource Metric

Element	Plan	Actual
Capital Service Cover	4	4
Liquidity	1	1
I&E Margin	4	4
I&E Variance From Plan		2
Agency	1	1
UoR Rating	3	3

6.3 Capital spend



Narrative

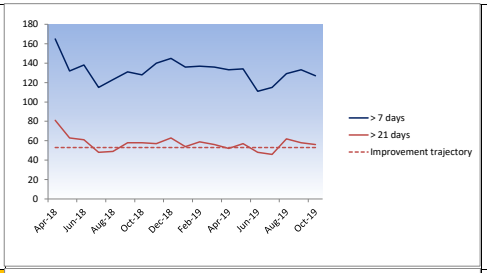
For the first time in 2019/20 the Trust reported an adverse position to plan in October. In month performance was a £674k surplus, £329k behind plan. This adverse position results in the year to date deficit being £1,712k, £217k behind plan.

The Trust reported a UoR rating of 3 in October.

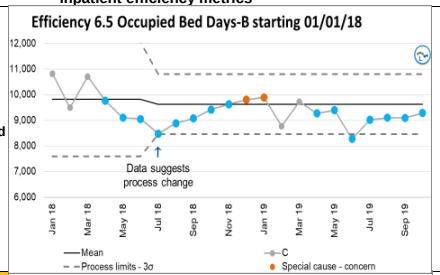
Further changes in relation to capital resources have been communicated, with the lifting of the previously communicated control total to the Trusts original planned level of expenditure. While this is positive, there remains a risk of being able to manage within this level of resource given proposed additions to the programme.

Inpatient efficiency metrics

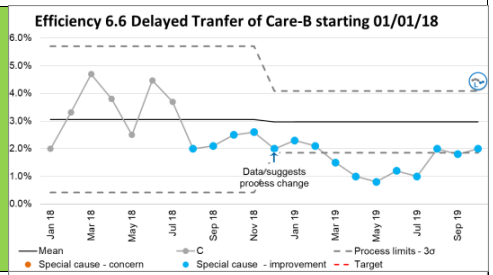
6.4 Long stay patients



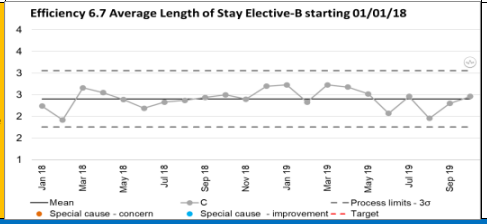
6.5 Occupied bed days



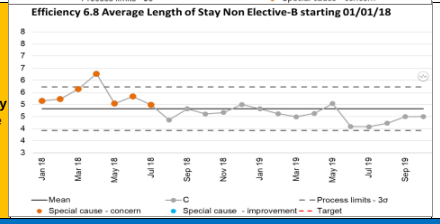
6.6 Delayed transfers of care



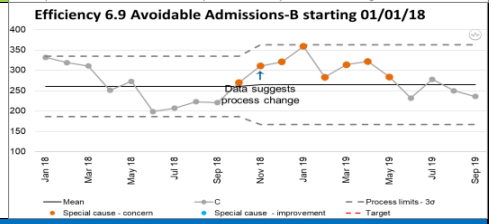
6.7 Length of stay - elective



6.8 Length of stay - non-elective



6.9 Avoidable admissions



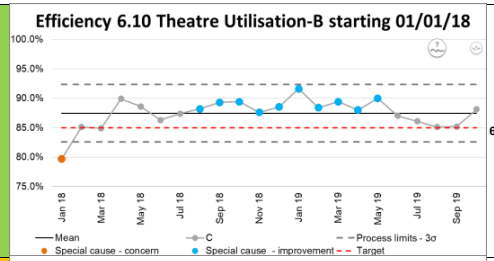
Narrative

Elective Length of stay increased to slightly above the Trust mean. Non electivelength of stay and avoidable admissions both remain below the Trust mean.

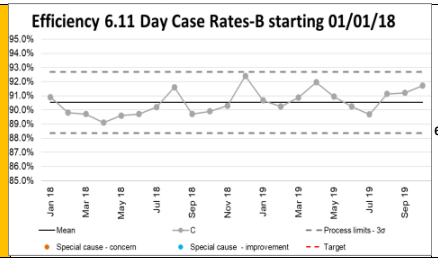
Section 6 - Efficiency and Finance - October 2019

Productivity metrics

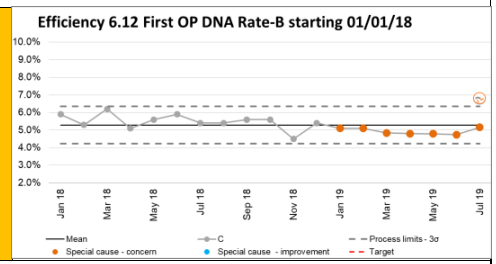
6.10 **Theatre utilisation**



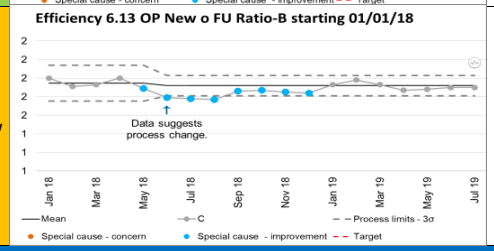
6.11 **Day case rate**



6.12 **Outpatient DNA rate**



6.13 **Outpatient new to follow up ratio**



Narrative

Theatre utilisation increased in October to above the target and Trust mean position. Daycase rates have increasedfor the third month running and OP DNA rates rem below the Trust mean.
New to Follow Up rattio increased slightly but also remains below the Trust mean.

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Section 7 - Activity - October 2019

Narrative

The tables below show activity by Point of Delivery by Contract Type: HaRD AIC; All Other CCGs (PbR); NHSE, Yorkshire Hub Cost per Case.

Trust total activity remains above commissioned levels, with elective activity in general in line with capacity available. When broken down to contract level, the HaRD AIC contract that is significantly over-performing and other PbR / cost per case contracts under-performing against elective commissioned levels. This continues to remain a concern as a result of the risk associated with significantly over-performing against an AIC contract.

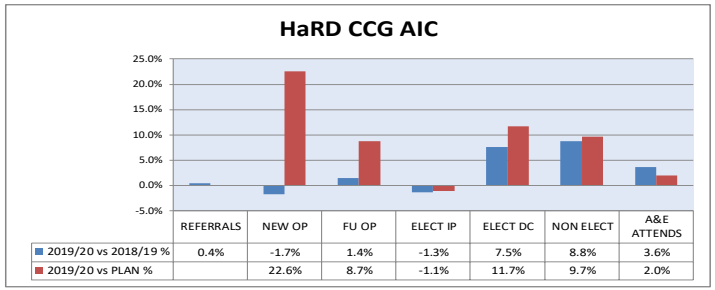
Work continues on the transfer of patients back to HDFT from Leeds, and also a longer term solution that ensures the future flow of work from the Leeds area. Patients transferring to HDFT from LTHT continue in Colorectal Surgery (69), Rheumatology (50), Dermatology (132) and Urology (64), total of 408 and we would expect to see these convert to activity in the coming months.

Non elective activity is above plan and also the same period last year.

Activity Summary

HaRD CCG AIC

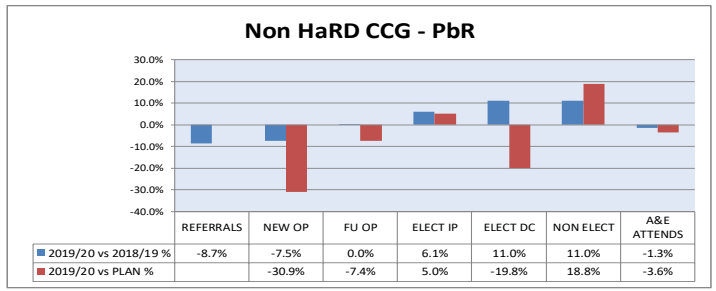
GROUP	2018/19 OCT	2019/20 OCT PLAN	2019/20 OCT ACTUAL	2018/19 YTD	2019/20 YTD PLAN	2019/20 YTD ACTUAL	2019/20 vs 2018/19	2019/20 vs PLAN	2019/20 vs 2018/19 %	2019/20 vs PLAN %
REFERRALS	3,449		3,509	22,594		22,688	94		0.4%	
NEW OP	6,283	4,783	6,123	40,079	32,140	39,396	-683	7,256	-1.7%	22.6%
FU OP	12,128	10,794	12,680	77,647	72,441	78,762	1,115	6,321	1.4%	8.7%
ELECT IP	196	205	173	1,283	1,280	1,266	-17	-14	-1.3%	-1.1%
ELECT DC	1,876	1,793	2,019	11,909	11,466	12,808	899	1,342	7.5%	11.7%
NON ELECT	1,566	1,545	1,592	9,843	9,762	10,706	863	944	8.8%	9.7%
A&E ATTENDS	3,375	3,206	3,274	22,072	22,417	22,867	795	450	3.6%	2.0%



Non-HaRD CCG - PbR*

GROUP	2018/19 OCT	2019/20 OCT PLAN	2019/20 OCT ACTUAL	2018/19 YTD	2019/20 YTD PLAN	2019/20 YTD ACTUAL	2019/20 vs 2018/19	2019/20 vs PLAN	2019/20 vs 2018/19 %	2019/20 vs PLAN %
REFERRALS	1,884		1,545	12,059		11,015	-1,044		-8.7%	
NEW OP	2,705	3,412	2,472	17,325	23,219	16,034	-1,291	-7,185	-7.5%	-30.9%
FU OP	4,530	4,596	4,678	28,667	30,981	28,674	7	-2,307	0.0%	-7.4%
ELECT IP	113	117	111	726	733	770	44	37	6.1%	5.0%
ELECT DC	719	1,042	768	4,767	6,601	5,293	526	-1,308	11.0%	-19.8%
NON ELECT	440	444	491	2,977	2,782	3,305	328	523	11.0%	18.8%
A&E ATTENDS	1,175	1,244	1,118	8,500	8,698	8,386	-114	-312	-1.3%	-3.6%

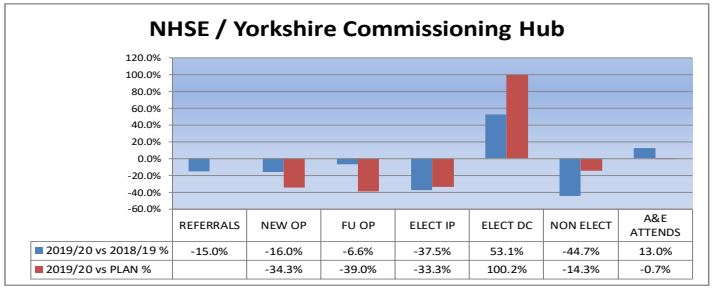
*Non-HaRD CCGs: Hambleton and Richmondshire CCG, Leeds CCG, Vale of York CCG, All Other CCGs



Harrogate and District NHS Foundation Trust

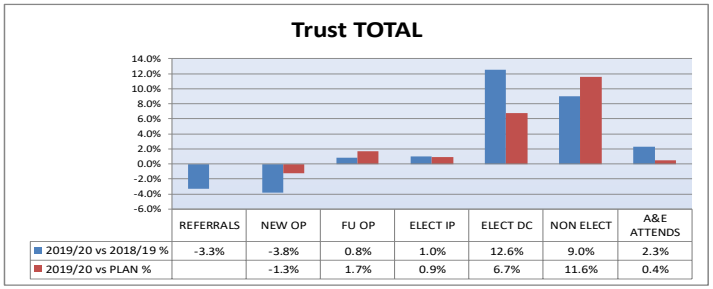
NHSE / Yorkshire Commissioning Hub

GROUP	2018/19 OCT	2019/20 OCT PLAN	2019/20 OCT ACTUAL	2018/19 YTD	2019/20 YTD PLAN	2019/20 YTD ACTUAL	2019/20 vs 2018/19	2019/20 vs PLAN	2019/20 vs 2018/19 %	2019/20 vs PLAN %
REFERRALS	285		202	1,660		1,411	-249		-15.0%	
NEW OP	219	354	314	1,855	2,370	1,558	-297	-812	-16.0%	-34.3%
FU OP	537	817	521	3,572	5,472	3,337	-235	-2,135	-6.6%	-39.0%
ELECT IP	4	2	1	16	15	10	-6	-5	-37.5%	-33.3%
ELECT DC	218	188	240	1,652	1,263	2,529	877	1,266	53.1%	100.2%
NON ELECT	13	7	9	76	49	42	-34	-7	-44.7%	-14.3%
A&E ATTENDS	26	21	33	131	149	148	17	-1	13.0%	-0.7%



Trust Total

GROUP	2018/19 OCT	2019/20 OCT PLAN	2019/20 OCT ACTUAL	2018/19 YTD	2019/20 YTD PLAN	2019/20 YTD ACTUAL	2019/20 vs 2018/19	2019/20 vs PLAN	2019/20 vs 2018/19 %	2019/20 vs PLAN %
REFERRALS	5,618		5,256	36,313		35,114	-1,199		-3.3%	
NEW OP	9,207	8,549	8,909	59,259	57,729	56,988	-2,271	-741	-3.8%	-1.3%
FU OP	17,195	16,207	17,879	109,886	108,894	110,773	887	1,879	0.8%	1.7%
ELECT IP	313	324	285	2,025	2,028	2,046	21	18	1.0%	0.9%
ELECT DC	2,813	2,567	2,708	18,328	19,330	20,630	2,302	1,300	12.6%	6.7%
NON ELECT	2,019	1,996	2,092	12,896	12,593	14,053	1,157	1,460	9.0%	11.6%
A&E ATTENDS	4,576	4,471	4,425	30,703	31,264	31,401	698	137	2.3%	0.4%



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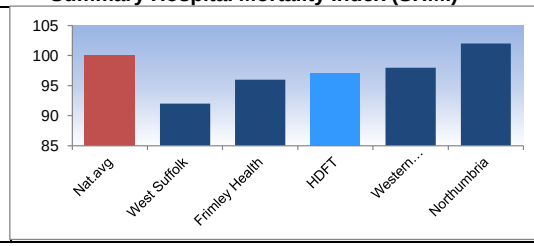
Section 8 - Benchmarking - October 2019

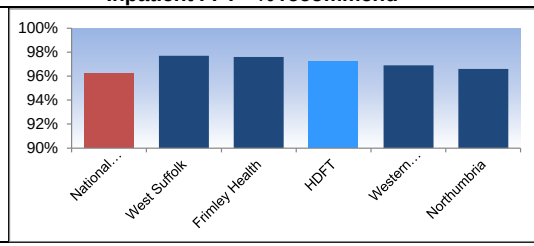
Summary Hospital Mortality Index (SHMI)

8.1



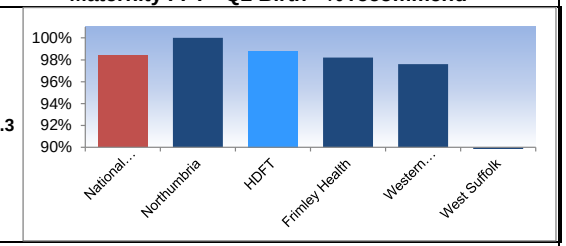
Inpatient FFT - % recommend

8.2



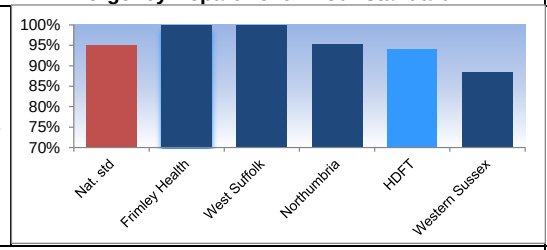
Maternity FFT - Q2 Birth - % recommend

8.3



Emergency Department 4 hour standard

8.4

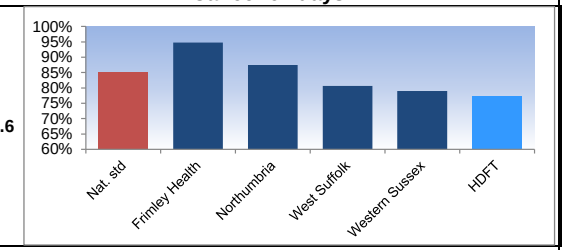


RTT incomplete pathways

8.5

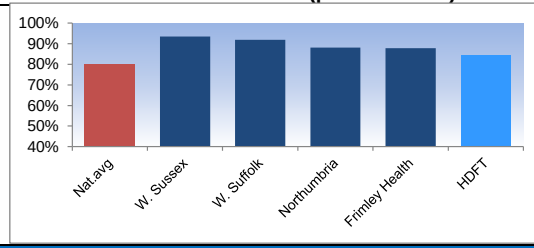
Cancer 62 days

8.6



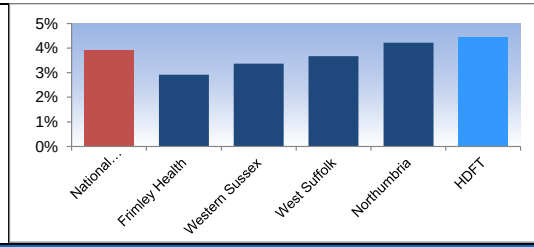
Staff FFT - % recommend (place to work)

8.7



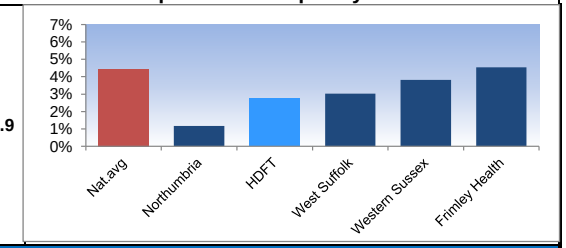
Sickness absence

8.8



Proportion of temporary staff

8.9



Narrative

The charts above show HDFT's latest published performance benchmarked against small Trusts with an outstanding CQC rating. The metrics have been selected based on a subset of metrics presented in the main report where benchmarking data is readily available. For the majority of metrics, the data has been sourced from NHSE Website, Data Statistics.

Harrogate and District NHS Foundation Trust

Integrated board report - August 2019

Key for SPC charts

Icon	Description
	Special cause variation - cause for concern (indicator where high is a concern)
	Special cause variation - cause for concern (indicator where low is a concern)
	Common cause variation
	Special cause variation - improvement (indicator where high is good)

Icon	Description
	Special cause variation - improvement (indicator where low is good)
	The system is expected to consistently fail the target
	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation

Harrogate and District NHS Foundation Trust

Data Quality - Exception Report

Domain	Indicator	Data quality rating	Further information
Safe	Pressure ulcers - community acquired - grades 2, 3 or 4	**Amber**	The observed increase in reported cases over the last two years may be partly due to improvements in incident reporting during the period.
Caring	Friends & Family Test (FFT) - Adult Community Services	**Amber**	The number of patients surveyed represents a small proportion of the community based contacts that we deliver in a year.
Efficiency and Finance	Theatre utilisation	**Amber**	This metric has been aligned with the new theatre utilisation dashboard from December 2017. Further metrics from the new dashboard are being considered for inclusion in this report from April 2018. The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. There are some known data quality issues with the utilisation data but it is anticipated that increased visibility of the data via the new dashboard will help to resolve these in the coming months.
Responsive	OPEL level - Community Care Teams	**Amber**	This indicator is in development.
Activity	Community Care Teams - patient contacts	**Amber**	During 2017/18, there were a number of restructures of the teams within these services and a reduction to baseline contracted establishment as the Vanguard work came to an end. This will have impacted upon the activity levels recorded over this period. Therefore caution should be exercised when reviewing the trend over time.

Indicator traffic light criteria

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Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
1.1	Safe	Pressure ulcers - hospital acquired	The chart shows the number of category 2, category 3, category 4 or unstageable hospital acquired pressure ulcers in 2018/19. The Trust has set a local trajectory for 2018/19 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes hospital teams only.	tbc	tbc
1.1	Safe	Pressure ulcers - hospital acquired	The chart shows the number of category 2, category 3, category 4, unstageable and DTI hospital acquired pressure ulcers, including device related and device related mucosal for 2019/20. The data includes hospital teams only.		
1.2	Safe	Pressure ulcers - community acquired	The chart shows the number of category 2, category 3, category 4 or unstageable community acquired pressure ulcers in 2018/19. This metric includes all pressure ulcers identified by community teams including pressure ulcers already present at the first point of contact. The Trust has set a local trajectory for 2018/19 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes community teams only.	tbc	tbc
1.2	Safe	Pressure ulcers - community acquired	The chart shows the number of category 2, category 3, category 4, unstageable and DTI community acquired pressure ulcers, including device related and device related mucosal for 2019/20. The data includes community teams only.		
1.3	Safe	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.	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%.
1.4	Safe	Safety thermometer - harm free care - community care teams	As above but including data for community teams only.		
1.5	Safe	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.	Blue if YTD position is a reduction of >=50% of HDFT average for 2018/19, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2018/19, Amber if YTD position is a reduction of up to 20% of HDFT average for 2018/19, Red if YTD position is on or above HDFT average for 2018/19.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
1.6	Safe	Infection control	HDFT's C. difficile trajectory for 2019/20 is 19 cases, an increase of 8 on last year's trajectory. This increase takes into account the new case assignment definitions. Cases where a lapse in care has been deemed to have occurred would count towards this. Hospital apportioned MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2019/20. The last reported case of hospital acquired MRSA at HDFT was in Oct-12.	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
1.7	Safe	Incidents - all	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	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.
1.8	Safe	Incidents - comprehensive SIRIs and never events	The number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services. Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the presure ulcer / falls indicators above.	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
1.9	Safe	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 provided in the narrative section and published on the Trust website.	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
2.1	Effective	Mortality - HSMR	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.	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.
2.2	Effective	Mortality - SHMI	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.		
2.3	Effective	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.	Blue if latest month rate < LCL, Green if latest month rate < HDFT average for 2018/19, Amber if latest month rate > HDFT average for 2018/19 but below UCL, red if latest month rate > UCL.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
3.1	Caring	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.	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
3.2	Caring	Friends & Family Test (FFT) - Adult Community Services	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 adult community services including specialist nursing teams, community care teams, community podiatry and GP OOH. A high percentage is good.		

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Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
3.3	Caring	Complaints	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.	Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2017/18, Amber if on or above HDFT average for 2017/18, 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.
4.1	Responsive	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 right shows how the Trust is performing against the national performance standards in the "operational performance metrics" section. From 1st April 2018, dementia screening perfromance forms part of this assessment.	As per defined governance rating	
4.2	Responsive	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.	Green if latest month >=92%, Red if latest month <92%.	NHS England
4.3	Responsive	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.	Blue if latest month >=97%, Green if >=95% but <97%, amber if >= 90% but <95%, red if <90%.	NHS England, NHS Improvement and contractual requirement of 95% and a locally agreed stretch target of 97%.
4.4	Responsive	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.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.5	Responsive	Diagnostic waiting times - 6-week standard	Percentage of patients waiting 6 weeks or less for a diagnostic test. The operational standard is 99%. A high percentage is good.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.6	Responsive	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.	Green if latest month >=90% for Step 1, Step 2 and Step 3, Red if latest month <90% for any of Step 1, Step 2 or Step 3.	NHS England, NHS Improvement and contractual requirement
4.7	Responsive	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.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.8	Responsive	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.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.9	Responsive	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.	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
4.10	Responsive	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.	Green if latest month >=94%, Red if latest month <94%.	NHS England, NHS Improvement and contractual requirement
4.11	Responsive	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.	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
4.12	Responsive	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.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.13	Responsive	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.	Green if latest month >=90%, Red if latest month <90%.	NHS England, NHS Improvement and contractual requirement
4.14	Responsive	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.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.15	Responsive	RTT waiting list split by weeks	Number of referred patients waiting for treatment broken down into weeks.	tbc	tbc
4.16	Responsive	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 North Yorkshire, Darlington, Co. Durham, Middlesbrough, Stockton, Gateshead and Sunderland. A high percentage is good.	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
4.17	Responsive	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 North Yorkshire, Darlington, Co. Durham, Middlesbrough, Stockton, Gateshead and Sunderland. A high percentage is good.	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
4.18	Responsive	Children's Services - Use of the Home Environment Assessment Tool	The % of eligible children in Durham who had a HEAT assessment. The performance target is 95%.	Green if latest month >=95%, Amber if between 90% and 94%, Red if <90%.	Contractual requirement
4.19	Responsive	Children's Services - Reports for Initial and Review Child Protection Case Conferences	The % of reports submitted prior to Case Conferences (where reports are reqeusted earlier than 48 hours before Case Conference.)	Green if latest month >=95%, Red if <95%.	Contractual requirement
4.20	Responsive	Children's Services - staff compliance with Safeguarding Supervision.	% of community staff achieving 80% compliance for Safeguarding Supervision.	Green if latest month >=100%, Red if <100%.	Locally agreed metric
4.21	Responsive	Children's Services - % achievement against KPI for Breast Feeding Prevalence at 6-8 weeks.	% of children breast fed at the 6-8 week review. Charted against Prevalence targets for all 0-5 services.	Green if latest month >=100%, Amber if between 90% and 99%, Red if <90%.	Contractual requirement
4.22	Responsive	OPEL level - Community Care Teams	The OPEL (Operational Pressures Escalation Level) is a measure of operational pressure being experienced by the community care teams. A value of 1 to 4 is agreed each day, with 1 denoted the lowest level of operational pressure and 4 denoting the highest. The chart will show the average level reported by adult community services during the month.	tbc	Locally agreed metric
4.23	Responsive	Community Care Teams - patient contacts	The number of face to face patient contacts for the community care teams.	tbc	Locally agreed metric
5.1	Workforce	Staff appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good.	Annual rolling total - 90% green. Amber between 70% and 90%, red<70%.	Locally agreed target level based on historic local and NHS performance
5.2	Workforce	Mandatory training rate	Latest position on the % substantive 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
5.3	Workforce	Staff sickness rate	Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%. A low percentage is good.	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

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Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
5.4	Workforce	Staff turnover	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.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
5.5	Workforce	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.	Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill.	Locally agreed targets.
6.1	Efficiency and Finance	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.	Green if on plan, amber <1% behind plan, red >1% behind plan	Locally agreed targets.
6.2	Efficiency and Finance	NHS Improvement Financial Performance Assessment	From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this, Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4.	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
6.3	Efficiency and Finance	Capital spend	Cumulative Capital Expenditure by month (£'000s)	Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan	Locally agreed targets.
6.4	Efficiency and Finance	Long stay patients	This indicator shows the average number of patients that were in the hospital with a length of stay of over 7 days (previously defined as stranded patients by NHS Improvement) or over 21 days (previously super-stranded patients). The data excludes children, as per the NHS Improvement definition. A low number is good.	tbc	as defined by NHS Improvement
6.5	Efficiency and Finance	Occupied bed days	Total number of occupied bed days in the month.	tbc	Locally agreed targets.
6.6	Efficiency and Finance	Delayed transfers of care	The proportion of bed days lost due to being occupied by patients who are medically fit for discharge but are still in hospital. A low rate is preferable. The maximum threshold shown on the chart (3.5%) has been agreed with HARD CCG.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement
6.7	Efficiency and Finance	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.	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.
6.8	Efficiency and Finance	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.		
6.9	Efficiency and Finance	Avoidable admissions	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 a hospital admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.	tbc	tbc
6.10	Efficiency and Finance	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. A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.
6.11	Efficiency and Finance	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.	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.
6.12	Efficiency and Finance	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.		
6.13	Efficiency and Finance	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.		
7.1	Activity	Outpatient activity against plan (new and follow up)	The position against plan for outpatient activity. The data includes all outpatient attendances - new and follow-up, consultant and non-consultant led.	Green if on or above plan in month, amber if below plan by < 3%, red if below plan by > 3%.	Locally agreed targets.
7.2	Activity	Elective activity against plan	The position against plan for elective activity. The data includes inpatient and day case elective admissions.		Locally agreed targets.
7.3	Activity	Non-elective activity against plan	The position against plan for non-elective activity (emergency admissions).		Locally agreed targets.
7.4	Activity	Emergency Department attendances against plan	The position against plan for A&E attendances at Harrogate Emergency Department. The data excludes planned follow-up attendances at A&E and pateints who are streamed to primary care.		Locally agreed targets.

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

Board Committee report to the Board of Directors

Committee Name:	Resources Committee
Committee Chair:	Maureen Taylor
Date of last meeting:	28 October 2019
Date of Board meeting for which this report is prepared	27 November 2019

Summary of live issues and matters to be raised at Board meeting:

1. The committee received information on the financial position in September 2019 which was a deficit of £158k, £112k ahead to plan. The year to date position is £26k ahead of plan.
2. The in-month key drivers for adverse variances were medical staffing, ward expenditure, commissioner income and NHS Property Services charges. These pressures have been offset by a number of favourable variances across a number of directorates including underspending in Children's and Countywide Community Care and a benefit from the pay award funding received from the Department of Health.
3. The CIP target for the year is £8.4m and to date CCCC and Corporate directorates have plans in place to deliver their targets. LTUC and PSC have plans totalling 91% and 94% of their targets respectively. Total plans in place total £8.5m which when risk adjusted falls to £7.8m.
4. The current forecast outturn position is £4m behind plan. Improvements to the financial forecast have been targeted to enable to Trust to meet its control total. The monthly resources review meetings are continuing to prove to be very positive providing a process through which directorate pressures are reviewed in detail and actions agreed to improve the financial position.
5. Trust total activity for August was ahead of commissioned levels. The HaRD Aligned Incentive Contract is significantly over performing, whilst other contracts are under performing. For HaRD CCG, all activity types were ahead of plan. This over-trade results in a calculation of the risk share for the Trust of £994k. Discussions are ongoing with HaRD CCG in relation to the costs of delivering the additional activity at present.
6. Work is continuing with Leeds to transfer patients back to Harrogate and to pursue a longer term solution that ensures future flow of work from Leeds. Leeds CCG has agreed to pay the contract value for 2019/20 which has mitigated the financial risk.
7. The workforce position in August showed substantive staffing down by 3.68 whole time equivalents (wte) against plan whilst bank and agency exceeded plan by 23 and 19 wtes respectively. There is a recruitment event plan in place to the end of the year. Detailed analysis of the areas

driving temporary staffing usage was presented as well as recruitment and retention plans. The Trust was below the agency cap in September. Measures are being taken to stem agency costs including maximisation of nursing rosters.

8. The consolidated cash position (Trust and HIF) for September continues to be ahead of plan. Performance against the better payment code has started to improve. Payment has been received of £1m of debts over 90 days. An improvement workshop around the invoicing and cash receivables process will be held in November.
9. Our Use of Resources rating stands at 3 (due to the planned deficits in the early part of the year) but is forecast to be 1 at the year end.
10. An update was received on the capital programme position highlighting changes to the programme so far in the year.
11. An update was received on Service Line Reporting (SLR) which includes a SLR monthly report which will be included for the Committee at each meeting and used in resource review meetings with Directorates.
12. A post project evaluation report on the establishment of Harrogate Integrated Facilities was presented.
13. A progress report on the WebV project was received highlighting progress in development of interfaces and documents but also delays in developing modules due to the inability to recruit staff.
14. The ICS financial position was reported as at Q2 which showed all organisations meeting plan. Failure to deliver the ICS plan could have financial implications for the Trust.
15. A paper was received setting out the protocol to be followed should the Trust wish to amend its financial forecast. There is no change to the protocol for providers.

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

- The AIC continues to over-trade and presents financial risk should this not be adequately addressed.

Matters for decision

None

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Board Committee report to the Board of Directors

Committee Name:	Resources Committee
Committee Chair:	Maureen Taylor
Date of last meeting:	25 November 2019
Date of Board meeting for which this report is prepared	27 November 2019

Summary of live issues and matters to be raised at Board meeting:

1. The committee received information on the financial position in October 2019 which was a surplus of £674k, £329k behind plan. The year to date position is £217k behind plan.
2. The in-month key drivers for adverse variances were medical staffing, ward expenditure, NHS Property Services charges and CIP delivery.
3. The CIP target for the year is £8.4m. To date risk adjusted plans in LTUC and PSC fall short of their targets but are more than compensated for by plans in CCCC and Corporate directorates.
4. The current forecast outturn position is £4m behind plan. Recent Resource review meetings with directorates have focussed on identifying plans to recover the position. Savings have been identified but there is still work to do.
5. Trust total activity for October was ahead of commissioned levels. The HaRD Aligned Incentive Contract is significantly over performing, whilst other contracts are under performing. For HaRD CCG, all activity types were ahead of plan. This over-trade results in a calculation of the risk share for the Trust of £1.1m. Discussions are ongoing with HaRD CCG in relation to the costs of delivering the additional activity at present.
6. Work is continuing with Leeds to transfer patients back to Harrogate. The Referral Service put in place by LTHT is being rolled back in all areas, reverting to previous referral arrangements. Capacity will be an issue when referrals start to feed through from Leeds.
7. The workforce position in August showed substantive staffing down by 6.72 whole time equivalents (wte) against plan whilst bank and agency exceeded plan by 26 and 7 wtes respectively. There is a recruitment event plan in place to the end of the year. Detailed analysis of the areas driving temporary staffing usage was presented as well as recruitment and retention plans. The Trust exceeded the agency cap in October but the year to date position is still below the cap. There was a discussion about Care Support Worker recruitment and sickness levels.
8. Following a period of clearing outstanding payments the consolidated cash position (Trust and HIF) for October is £1.5m behind plan. As expected, performance against the better payment code has started to

improve. Payment has been received of £1m of debts over 90 days but large sums are still outstanding. An improvement workshop around the invoicing and cash receivables process will be held in November.

9. Our Use of Resources rating stands at 3 (due to the planned deficits in the early part of the year) but is forecast to be 1 at the year end.
10. The Service Line Reporting overview was reviewed which shows profitability by point of delivery and by specialty. Data relating to Ophthalmology was discussed and the need to link the SLR information to the Carnell Farrar review. It would also be useful to see Reference Costs for the services shown.
11. Work-streams have been initiated to deliver the Operational Plan for March 2020 although Planning Guidance is still awaited. A reporting timetable was put forward for scrutiny by the Resources Committee, of the various elements of the planning information.
12. The Committee received and discussed two business case reports; the first for the provision of a new CT suite partly funded by an external cash investment and the second for implementation of phase 2 of the Ambulatory Care Unit. Both business cases will be presented to the Board of Directors for approval
13. It was noted that the Board of Directors would be carrying out scrutiny of the in-month financial position at its workshop in December and so the December Resources Committee would largely focus on planning for 2020/21 and how the Model Hospital work will feed into efficiency planning.

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

- The AIC continues to over-trade and presents financial risk should this not be adequately addressed.
- Delivery of the recovery plan savings that are needed to deliver the year end control total

Matters for decision

None

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Harrogate and District
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Financial Summary

Financial Position

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For the first time in 2019/20 the Trust reported an adverse position to plan in October. In month performance was a £674k surplus, £329k behind plan. As outlined below, this adverse position results in the year to date deficit being £1,712k, £217k behind plan. The drivers for this are described in more detail on page 2 of the report.

HDFT Monthly Financial Performance (£'000s)

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Actual	-1,677	-67	-256	326	-554	-158	674					
Internal Plan	-2,111	349	-286	328	-568	-270	1,003	613	579	1,479	1,049	1,833

HDFT Cumulative Financial Performance (£'000s)

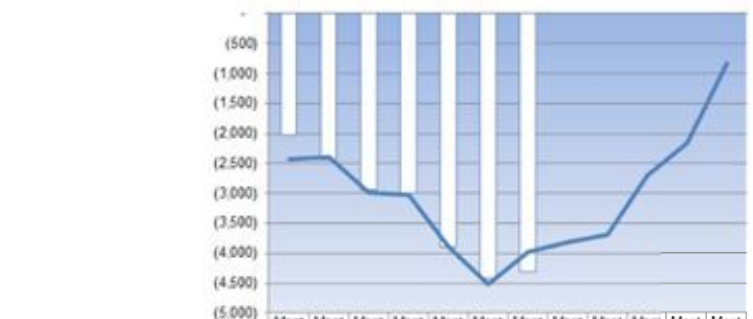
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Actual	-1,677	-1,744	-2,000	-1,674	-2,228	-2,386	-1,712					
Internal Plan	-2,111	-1,762	-2,048	-1,720	-2,228	-2,498	-1,495	-882	-303	1,176	2,225	4,058

The adverse position is clearly a concern, risking quarter 3 and 4 Provider Sustainability Funding if improvements are not made. The total impact of this would be a minimum of £1.8m, with a subsequent impact on the capital resource available in future years. Performance against the control total is outlined below

HDFT Monthly Control Total Performance (£'000s)

	Mont h 1	Mont h 2	Mont h 3	Mont h 4	Mont h 5	Mont h 6	Mont h 7	Mont h 8	Mont h 9	Mont h 10	Mont h 11	Mont h 12
Performance against Control Total	(2,020)	(410)	(514)	(47)	(903)	(518)	107					
Control Total (excl PSF)	(2,426	34	(600)	(33)	(869)	(630)	550	160	126	980	550	1,334

HDFT Cumulative Control Total Performance (£'000s)



	Mont h 1	Mont h 2	Mont h 3	Mont h 4	Mont h 5	Mont h 6	Mont h 7	Mont h 8	Mont h 9	Mont h 10	Mont h 11	Mont h 12
Performance against Control Total	(2,020	(2,430	(2,944	(2,991	(3,894	(4,412	(4,306					
Control Total (excl PSF)	(2,426	(2,392	(2,992	(3,025	(3,894	(4,524	(3,974	(3,814	(3,688	(2,708	(2,158	(824)

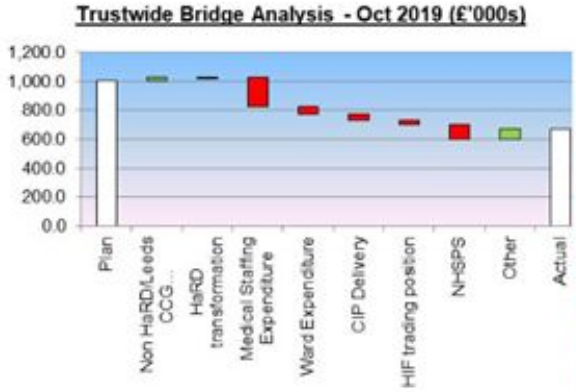
The overarching position emphasises the need to implement recovery plans and improve the underlying financial run rate.

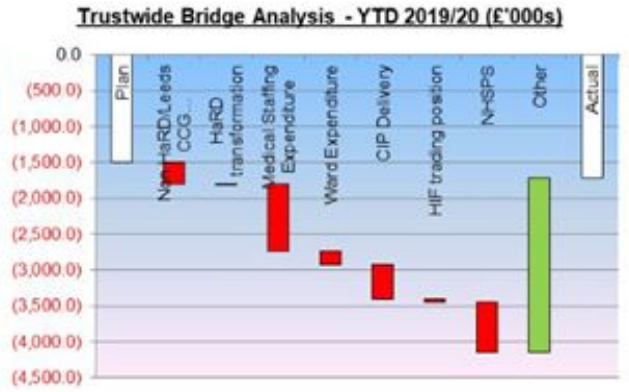
Financial Position

Harrogate and District NHS Foundation Trust

The information below highlights the key drivers for the in month and year to date financial position.

Variance to Budget	Oct (£'000s)	YTD (£'000s)
Plan	**1,003**	**(1,495)**
Non HaRD/Leeds CCG Commissioner Income	25	(302)
HaRD transformation	-	-
Medical Staffing Expenditure	(206)	(937)
Ward Expenditure	(51)	(194)
CIP Delivery	(41)	(482)
HIF trading position	(30)	(41)
NHSPS	(100)	(700)
Other	74	2,438
Actual	**674**	**(1,712)**





The above provides the drivers for the Trusts current financial position, in particular the adverse trends which are impacting the position and being offset with non recurrent measures. Areas to note include –

- There are some small improvements in non HaRD/Leeds NHS commissioner income, predominantly relating to patients from Hambleton, Richmondshire and Whitby CCG. There remain some underlying adverse trends which are being looked into.
- Activity with HaRD CCG continues to trade at levels in excess of the Aligned Incentive Contract agreement, the current contract overtrade standing at £1.7m to the end of month 7, accounting for the Trusts contribution to system affordability.
- Medical staffing expenditure continues to be a pressure, with a relatively small number of issues driving some significant expenditure.
- Ward expenditure continues the overall adverse trend reported last month, expanding to both RN and CSW pressures. The position includes a provision of £30k per month that was established through additional CIP at the beginning of the year.

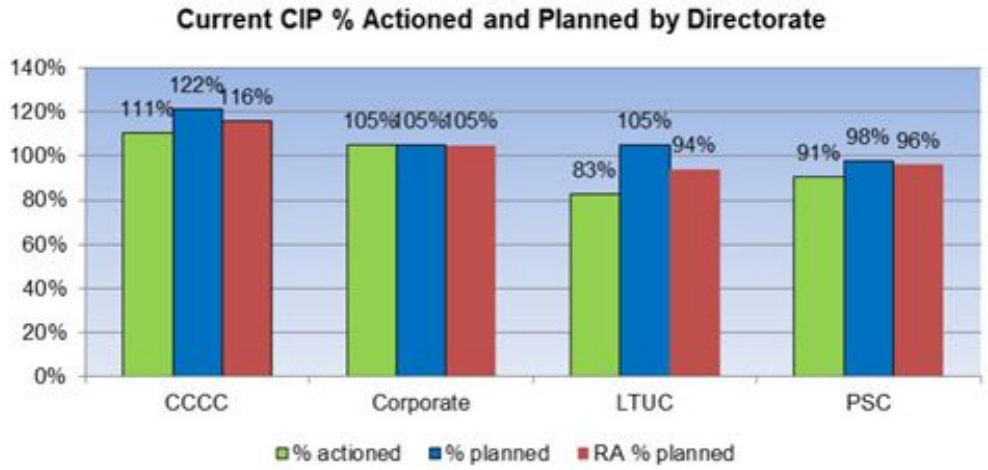
As described in previous months, the run rate needed to improve to mitigate these pressures. While some of it has been, the adverse position to plan clearly shows the need for continued work and focus in this area.

CIP Performance

Harrogate and District NHS Foundation Trust

Directorate Level CIP Performance is highlighted below –

	CCCC	Corporate	LTUC	PSC	Total
Target	**1,700**	**2,206**	**2,255**	**2,245**	**8,406**
High	100	-	273	27	400
Medium	57	-	76	42	175
Low	30	-	156	90	276
Actioned	1,879	2,314	1,866	2,040	8,099
Total	**2,066**	**2,314**	**2,371**	**2,199**	**8,950**
RA Total	1,971	2,314	2,122	2,160	8,568



Forecast Outturn

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The forecast position is summarised in the table below, with movements described between the previous month forecast and against the control target.

£'000s	Year End Forecast as at Sept 2019	Year End Forecast as at Oct 2019	Change in forecast between months		Year End Target Achieve Control Target	Improvement to current forecast
Commissioner Income	225,291	225,291	0		226,791	1,500
CCCC	-53,715	-53,710	-5		-53,715	0
Corporate	-36,147	-36,309	162		-36,044	265
LTUC	-71,706	-71,856	150		-71,422	434
PSC	-70,770	-70,821	51		-70,403	418
Other	6,946	7,446	-500		8,651	1,205
Trust Position	**-101**	**41**	**142**		**3,858**	**3,817**
HIF Surplus	0	0	0		200	200
Group Position	**-101**	**41**	**142**		**4,058**	**4,017**
Control Total	**4,058**	**4,058**			**4,058**	
Variance	**-4,159**	**-4,017**	**142**		**0**	

Key changes described above are –

- The Corporate Forecast deteriorated at month end due to a number of factors across a broad range of areas. The Director Team tasked the directorate with implementing a plan to recover this. Plans currently improve the position to a forecast of £36.3m, £265k behind the improvement target. Whilst the improvement is positive, there is still work to do in order to close the gap above.

- The position within LTUC remains challenging, with a number of issues being worked through and addressed. There are a number of actions being taken forward, however, the gap to control target remains £434k.

- The changes in forecast position in PSC were less material between months and there remains focus on the recovery plan. This is moving forward positively, however, there are still risks that will need managing.

- The income forecast has not been adjusted between months while a number of issues are further investigated and understood. The improvement position is currently being discussed with commissioners, both with local CCGs (HaRD and Leeds) and with NHSE.

- The CCCC directorate continue to maintain their positive performance.

Forecast Outturn

Harrogate and District NHS Foundation Trust

Detailed discussions and analysis at the recent Resource Review meetings for PSC and LTUC centred on plans to recover these positions, with a similar discussion happening at Corporate Board. Current plans are summarised below for discussion at SMT, and more detailed work is available to support this.

Directorate	Saving Requirement (£'000s)	Current Assessment of Plans (£'000s)
Planned and Surgical Care • Appropriately reflecting winter expenditure following review of what is required • Delivery of significant WLI reduction • Review of Medical Workforce expenditure pressures for alternatives (with QIA) • Local management of vacancies • Focus on discretionary spend • Alternative use of NHSR incentive funds • Close review and management of bowel screening/bowelscope/FIT roll out income and expenditure	418	320
Long Term and Unscheduled Care • Appropriately reflecting winter expenditure following review of what is required • Review of Medical Workforce expenditure pressures • Deep dive into pathology services to reduce overspend and ensure the benefits of the JV are delivered • Focus on diabetic pumps to reduce spend in the second half of the year • Managing Cancer Performance within allocations • Targeting all budget holders to restrict non-pay spend	434	252
Corporate Services • Stronger vacancy control management • Block in place for overtime/additional hours in most areas • Controls in place in relation to discretionary spend, reassessing requirements where appropriate • Ensure recharges to other organisations are in place	265	150

As well as the above, progress is being made with the central actions required.

Harrogate and District
NHS Foundation Trust

Directorate Positions

Directorate Position

Harrogate and District NHS Foundation Trust

Planned and Surgical Care

The directorate delivered the forecast spend in October. The position currently is a overspend of £0.4m, with a forecast without further action of a year end deficit of £0.4m – effectively breakeven to the end of the year. Positive actions have been implemented, in particular

- Delivery of CIP schemes, with only £40k left outstanding
- Reduction in WLI spend, with £60k less spent in October than September

Included within the year end forecast to date is the one-off pension charge relating to a particular member of staff. This charge is £220k.

Further plans to benefit the position over and above actions being implemented and part of the forecast include -

- Further review of WLI expenditure and requirement, especially in outpatients
- Recovery of excess costs from TEWV in relation to a patient with mental health needs
- General holding of vacancies
- Discretionary expenditure
- Use of the NHSR incentive payment to support the revenue position whilst delivering the necessary improvements differently

Children's and Countywide Community Care

The favourable financial performance within the directorate continued in October, with a favourable variance of £137k reported in month.

The performance in October was in line with the Directorate forecast.

The pay position for the Directorate remains underspent, with the planned phasing of expenditure through winter in relation to the flu service being seen as predicted.

The Directorate continues to forecast an underspend at the end of the year of £1.1m.

Directorate Position

NHS
Harrogate and District
NHS Foundation Trust

Long Term and Unscheduled Care

The directorate's performance in month was above the forecast as shown in the graph below. Part of the issue identified relates to costs from previous months that were not anticipated or accrued for. Significant work has been undertaken over the last week to ensure that the forecast going forward is robust and that all leaders within the Directorate own and sign up to the issue and necessary actions..

Key areas of pressure for the directorate remain ward and medical staffing expenditure.

Currently the forecast is to overspend by £434k.

Actions being taken include:

- Deep dive into pathology expenditure to reduce current overspend and to ensure that the benefits of the JV are realised
- Analysis of the increase in relation to diabetic pumps to restrict expenditure in the second half of the year (we have experienced step change in demand)
- Medical staffing controls in respect of agency/locum
- Targeting all budget holders to restrict non-pay spend each month for the rest of the year
- Reassessment of the forecast cost of winter nursing, which is currently assuming significant agency cost

The current risk assessment of the actions is that there remains a risk of c£250k to manage over the next 5 months.

Corporate Services

The forecast position for corporate is outlined in the graph below.

Whilst the in-month position was delivered as forecast for the Corporate Directorate, the forecast outturn has worsened by £65k to £265k.

In order to address the gap in forecast outturn the directorate is implementing a range of measures:

- strengthening the vacancy control process and implementing a block on additional hours and overtime in areas where this could be managed without clinical risk.
- Reviewing the use of R&D funds
- Challenging all budget holders to contribute to restrictions on non-pay spend

The Directorate helpfully had its first Resource Review Meeting this month, which was constructively challenging and has helped to ensure a consistent message of what is required to be delivered across the team.

Harrogate and District
NHS Foundation Trust

Cashflow and Balance Sheet

Cashflow, Debtors and Creditors

Harrogate and District NHS Foundation Trust

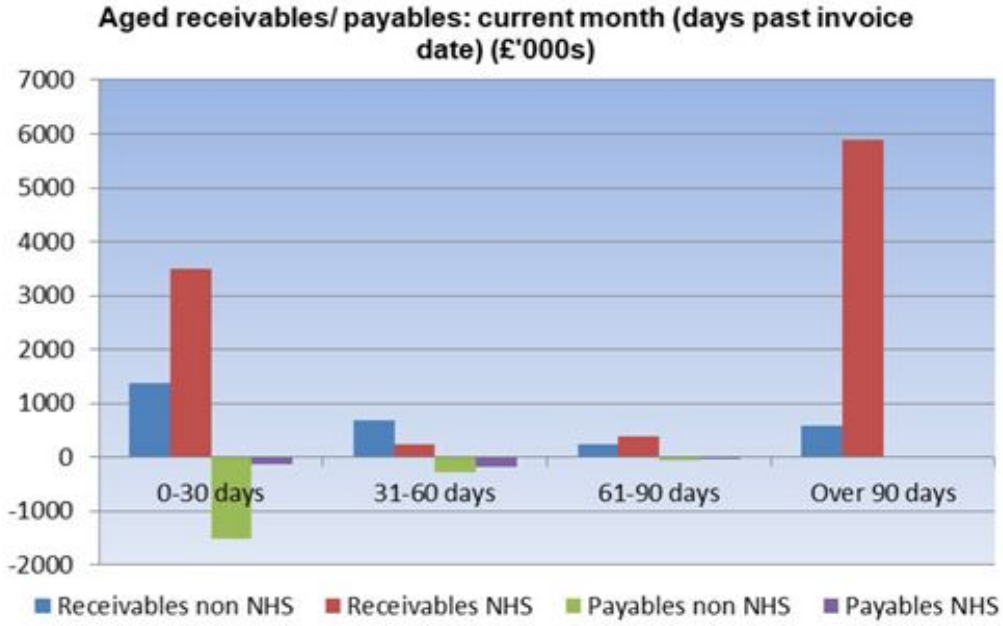
As anticipated, the Trusts cash position is returning to levels below plan based on the need to improve the payments performance and the current revenue position.

Cash forecasting is currently being developed and will be added to the report.

Overall, aged payables have reduced marginally since July. Positively the Trust has received payment for £1m of debts over 90 days.

As predicted last month, performance in relation to BPPC has started to improve.

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Plan	1,238	843	1,574	1,317	4,418	4,350	4,895	4,826	6,478	6,813	6,482	9,682
18/19 Actual	976	2,674	2,878	3,905	3,257	395	2,243	1,312	4,171	1,545	626	2,912
Actual	1,550	1,325	2,900	8,950	7,448	6,518	3,407					
Forecast							3,407					



BPPC % of bills paid in target	Year to date		
	Current month	Previous month	Movement
Non NHS			
- By number	**8.7%**	**7.5%**	**1.2%**
- By value	**9.2%**	**8.1%**	**1.2%**
NHS			
- By number	**9.4%**	**8.8%**	**0.6%**
- By value	**39.0%**	**41.0%**	**(1.9%)**

Balance Sheet and Use of Resources

Harrogate and District NHS Foundation Trust

The table to the right outlines a summary balance sheet position as at October 2019.

The impact of the year end valuation of the site was not accounted for in the plan, and therefore non current assets will continue to have a variance during the year.

Statement of financial position summary	Current month			
	Plan £000s	Actual £000s	Variance £000s	%
Non-current assets	101,245	93,615	(7,630)	**(7.5%)**
Current assets	24,894	33,923	9,029	**36.3%**
Current liabilities - borrowings	(2,212)	(2,198)	14	**0.6%**
Current liabilities - other	(13,809)	(18,065)	(4,256)	**(30.8%)**
Total assets less current liabilities	**110,118**	**107,275**	**(2,843)**	**(2.6%)**
Non-current liabilities - borrowings	(16,164)	(16,164)	0	**0.0%**
Non-current liabilities - other	(136)	(147)	(11)	**(8.1%)**
Total net assets employed	**93,818**	**90,964**	**(2,854)**	**(3.0%)**

The Trust Use of Resources Risk Rating is outlined below.

Finance and use of resources rating	Expected Sign	03AUDITPY Audited PY 31/03/2019 Year ending Number	03PLANYTD Plan 31/10/2019 YTD Number	03ACTYTD Actual 31/10/2019 YTD Number	03VARYTD Variance 31/10/2019 YTD Number	03PLANCY Plan 31/03/2020 Year ending Number	03FOTCY Forecast 31/03/2020 Year ending Number
Capital service cover rating	+	1	4	4		2	2
Liquidity rating	+	1	1	1		1	1
I&E margin rating	+	1	3	4		1	1
I&E margin: distance from financial plan	+	1		2			1
Agency rating	+	1	1	1		1	1

Overall finance and use of resources risk rating	Expected Sign	03AUDITPY Audited PY 31/03/2019 Year ending Number	03PLANYTD Plan 31/10/2019 YTD Number	03ACTYTD Actual 31/10/2019 YTD Number	03VARYTD Variance 31/10/2019 YTD Number	03PLANCY Plan 31/03/2020 Year ending Number	03FOTCY Forecast 31/03/2020 Year ending Number
Overall rating unrounded	+	1		2.40			1.20
If unrounded score ends in 0.5	+	0		0.00			0.00
Risk ratings before overrides	+	1		2			1
Risk ratings overrides:							
Any ratings in table 6 with a score of 4 override - if any 4s "trigger" will show here	Text	No trigger		Trigger			No trigger
Any ratings in table 6 with a score of 4 override - maximum score override of 3 if any rating in table 6 scored as a 4	+	1		3			1
Control total override - Control total accepted	Text	Yes		Yes			Yes
Control total override - Planned or Forecast deficit	Text	No		No			No
Control total override - Maximum score (0 = N/A)	+	0		0			0
Is Trust under financial special measures	Text	No		No			No
Risk ratings after overrides	+	1		3			1

Harrogate and District NHS Foundation Trust

Date of Meeting:	27 November 2019	**Agenda item:**	**5.4**
Report to:	Board of Directors		
Title:	Operational Performance Report		
Sponsoring Director:	Mr Robert Harrison, Chief Operating Officer		
Author(s):	Mr Paul Nicholas, Deputy Director of Performance & Informatics Mr Jonathan Green, Principal Information Analyst		

Report Purpose:

Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓

Executive Summary:

- Six of the seven applicable Cancer Waiting Times standards were achieved for October, with the exception of the 62 day Screening Standard (monitored on a monthly basis).
- HDFT's performance against A&E 4-hour standard was 90.4% in October and year-to-date is at 91.3%. These are below the 95% standard.
- The Trust had no-one waiting longer than 52 weeks on the RTT waiting list at the end of October. There were a total of 15,859 patients waiting on the list; this includes 150 Dental patients and is above our agreed trajectory of 15,750.

Related Trust Objectives

To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓

Key implications

Risk Assessment:	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 operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence;
Legal / regulatory:	Risk to segmentation based on the Single Oversight Framework
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None
Reference documents:	
Assurance:	

Action Required by the Board of Directors:

It is **recommended** that the Board:

- **Notes** items included in the report.

10

You matter most

OPERATIONAL PERFORMANCE REPORT

1.0 SERVICE ACTIVITY

Trust total activity remains above commissioned levels, with elective activity in general in line with capacity available. When broken down to contract level, the HaRD AIC contract that is significantly over-performing and other PbR/cost per case contracts under-performing against elective commissioned levels. This remains a concern as a result of the risk associated with significantly over-performing against an AIC contract.

Elective activity for the year-to-date is 11.4% higher than the same period last year with 62% of the additional activity originating from non-HaRD CCGs – there has been a 6.7% increase in HaRD elective activity (13,192 vs 14,074), and a 20.1% increase in non-HaRD elective activity (7,161 vs 8,602), although the latter remains very slightly below plan (8,602 vs 8,612).

At the end of October Non-Elective Activity is 9% above the same time period last year, across all commissioners. This has meant that the hospital site has had to maintain escalation capacity beyond the plan for this year. The number of long stay patients (>21 days) remained static at around 60 patients in October, but in recent weeks we have seen a decrease to 57 which is only 7 away from the target of 50. However, this remains a concern and work is ongoing to ensure actions are undertaken to further reduce the number of acute admissions and facilitate earlier discharge where appropriate.

Referrals from Leeds CCG increased by 9.9% compared to last month, but year to date are down by 11.1% when compared to the same period last year. Work continues on the transfer of patients back to HDFT from Leeds, and also a longer term solution that ensures the future flow of work from the Leeds area. Patients transferring to HDFT from LTHT continue in Colorectal Surgery (69), Rheumatology (50), Dermatology (132), Gynaecology (93), and Urology (64), total of 408, and we would expect to see these convert to activity in the coming months.

Non elective activity is above plan and also the same period last year.

2.0 RTT WAITS

There were a total of 15,859 patients on the RTT waiting list at the end of October; this is above our agreed trajectory of 15,750 and includes 150 Dental patients. Dental Services was not included in our trajectory. Dental RTT issue is an in year change to the commissioner specification which means all community dental referrals are now deemed to be to a Consultant led service from the 01 October 2019 and therefore included in the return. This has been highlighted to colleagues in NHSI. There were no patients waiting over 52 weeks at the end of the month.

3.0 EMERGENCY DEPARTMENT PERFORMANCE

HDFT's Trust level performance against the 4-hour standard was 90.4% in October, below the required 95% standard and below the trajectory of 93.8%. This includes data for the Emergency Department at Harrogate and Ripon MIU. The Trust is therefore currently below the required standard for the year-to-date with a Trust level performance of 91.3%.
The ED Recovery Programme task and finish group have now met on two occasions with a key focus on ED capacity, Specialty ownership / review in department, and Patient flow.

4.0 CANCER WAITING TIMES

Provisional data indicates that 6 of the 7 applicable Cancer Waiting Times standards were achieved in October, with 62 day Screening performance below the operational standard of 90% - 8 Bowel Screening patients were treated in the month (4 Leeds, 3 Harrogate, 1 York) and 4 of these received treatment after 62 days (3 Leeds, 1 Harrogate). These delays were due to pathway complexity and other clinical factors. Of the 4 patients treated at Leeds, 3 were transferred to Leeds by day 38, meaning that the total accountable Screening denominator was 5.0 with 1.5 patients treated after day 62 (70%).

Provisional data report that there were 56.5 accountable 62 day standard treatments in the month with 7.0 breaches, meaning performance was above the standard at 87.6%. Of the 11 tumour sites, 6 had performance below 85% in October - Breast (1 actual breach, 1.0 accountable), Head and Neck (1 actual breach, 1.0 accountable), Lung (2 actual breaches, 1.5 accountable), Upper GI (3 actual breaches, 1.5 accountable), and Other (2 actual breaches, 1.0 accountable). 4 patients waited over 104 days for treatment in October - these were due to a combination of pathway complexity, clinical suspension, patient choice/holiday, and elective capacity at Leeds - all breaches and near misses are scheduled to be reviewed at breach analysis towards the end of November.

We have experienced a significant increase in breast referrals following the National breast awareness campaign resulting in a risk that we will not deliver the 14 Day Breast cancer standard in November.

5.0 NHS ENGLAND – PUBLIC HEALTH COMMISSIONING

We have recently had a constructive meeting with NHS England (NHSE) to discuss Bowel Screening demand and challenges experienced by the Community Dental Services.

The over-performance of bowel screening activity against the NHSE contract follows the significant increase in uptake of the FIT programme, and NHSE have requested further details of the resulting cost pressure being experienced by the Trust. Further discussions will take place through contracting for 2020/21 to take into account the continued increase in Bowel Screening activity and higher detection rates and the impact on costs. In addition, the opportunity to undertake additional work was discussed to reduce average waits (and long waits) for patients; this would be funded as additional in 2019/20.

For Community Dental Services NHSE will consider the viability of an Estates feasibility study being funded to support the transformation of the service in North Yorkshire, and review the ability to support the funding of recurrent pressures caused by the increase in GA costs where the service is renting theatres from other organisations and the impact of the Medical and Dental Pay award. The opportunity for non-recurrent funding to support reductions in the GA waiting list was also discussed where we would look to support this based on the availability of practitioners and theatres. Further discussions in respect of 2020/21 and beyond regarding the ability for funding to be equalised upwards for the North Yorkshire service, recognising that it is the lowest funded in the region for the activity and services it is expected to deliver.

6.0 WINTER READINESS: 2019/20

The Harrogate and District A&E Delivery Board is completing a response to the letter outlining expectations for Winter Readiness received from West Yorkshire and Harrogate Health and Care Partnership.

7.0 INFORMATION COMMISSIONER'S OFFICE (ICO) AUDIT

The Information Commissioner's Office (ICO) carried out an audit at the Trust over 2 days in October. We have received the draft report that identifies a number of proposed actions

linked to the three areas covered in the audit: Cyber Security; Personal Data Breach Management and Business Continuity. The audit was a positive and helpful process and none of the proposed actions identified are a cause for concern.

MD report for BoD November 2019.

1. **Mortality update**

Following the discussion that took place at a recent Board meeting regarding implementation of the ReSPECT process, I have engaged informally with a number of key stakeholders. It is intended to progress this work through the RPIW quality improvement methodology process. I am liaising with David Plews and will update Board on progress.

At the time of writing I have arranged to meet with the newly appointed Regional Medical examiner in order to discuss details of the structure and requirements for the new Medical Examiner role.

2. **Research Update:**

Whilst seeking to maintain recruitment targets against a backdrop of falling regional CRN funding allocations for research, the outlook seems challenging. Essentially the position for 2020/21 is flat cash, with additional pressures in relation to staff AfC pay awards and superannuation increases of employer contributions. It is anticipated the overall income reduction across the region will be in the regional of 5%, no doubt passed on to provider organisations. The CRN YandH are appointing a new COO in te New Year who will no doubt be tasked with discussing impact and mitigation with providers. In the meantime discussions are planned internally between the research lead and finance department to try and get ahead of the curve in understanding the imapct.

3. **Inquest update**

Two recent inquests have been held.

The first concerned the death of a patient following elective laparoscopic surgery. A number of staff were called to give oral evidence and more statements were read. This was an exceptionally difficult process for family members and staff alike. I would like to send my thanks and appreciation to all staff who conducted themselves in a disciplined and professional manner whilst still clearly demonstrating respect and sympathy for the feelings of family members. This was particularly evident under what was, at times, hostile questioning from legal representatives of the family.

The Coroner recorded a narrative verdict. This was factual and no criticism was directed at any individual or the Trust. The Coroner was satisfied with the action plan that was presented to him. No regulation 28 rule was issued.

At the time of writing, a second inquest has concluded. I will be able to update Board verbally.

4. **GMC update**

The independent review by Leslie Hamilton into how the law on gross negligence and manslaughter are applied to medical practice was commissioned by the GMC in January 2018 following the death of Jack Adcock and the prosecution and conviction of Dr Bawa-Garba. Although GNM prosecutions are rare, it raised a number of concerns about criminalisation in medical practice, particularly where the risk of patient death is constant, and in the context of systemic pressure.

Following engagement with stakeholders, including families, doctors, healthcare service providers, lawyers and a dedicated group of experts in Scotland where the systems and law differs from the other UK countries, the working group made 29 recommendations focused on creating a just culture in healthcare and improving consistency across local, coronial, criminal and regulatory processes.

The GMC welcomes and accepts all recommendations for the GMC which include:

- **rebuilding doctors' trust in our readiness to support them in delivering good medical practice for patients (recommendation 2)**
- **putting in place methods of assuring fair decisions, such as equality, diversity and inclusion training,**
- **unconscious bias training, and auditing and monitoring (recommendation 9)**
  striving to reduce the timescales for progressing fitness to practise cases to Medical Practitioner Tribunals (recommendation 24

A number of other GMC reports are available to the interested reader.

- The reflective practitioner
- supporting a profession under pressure
- workforce report
- How doctors in senior leadership roles establish and maintain a positive patient-centred culture

5. **Safety update:**

HSIB report:

The Trust has received a national report from the Healthcare Safety Investigation Branch for the period 1st April 2018 to 31st august 2019. Much of the report relates to the national programme of investigations so far. A copy of the data pack which details, amongst other things, national areas of learning and thematic observations can be found in the reading room.

From a local perspective, HSIB has investigated 2 of 4 referrals. Two were rejected as inadvertent duplicates of one case. Of the two investigated, one report is complete. No serious concerns have been raised and the overall view was that local management was satisfactory.

National patient safety Strategy:

A summary of a rather extensive and innovative strategy follows:

A patient safety culture and a patient safety system. Three strategic aims will support the development of both:

1. Improving understanding of safety by drawing intelligence from multiple sources of patient safety information (Insight)
2. Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (Involvement)

3. Designing and supporting programmes that deliver effective and sustainable change in the most important areas (Improvement).

Patient safety culture

Key features

- Psychological safety for staff - compassionate environment. Psychological safety operates at the level of the group not the individual, with each individual knowing they will be treated fairly and compassionately by the group if things go wrong or they speak up to stop problems occurring. It means staff do not feel the need to behave defensively to protect themselves and instead opens the space in which they can learn
- Diversity - inclusivity, trust and respect
- Compelling vision
- Leadership and teamwork - compassionate leadership, teams - high performing teams promote a culture of honesty, authenticity and safe conflict.
- Open to learning
- Behaviours - kindness and civility - role model the right behaviour, reward good behaviour and deal with bad behaviour. The behaviours that counter incivility are often small; smile and say hello in the hallway, say thank you, recognise what people do, listen with intent.

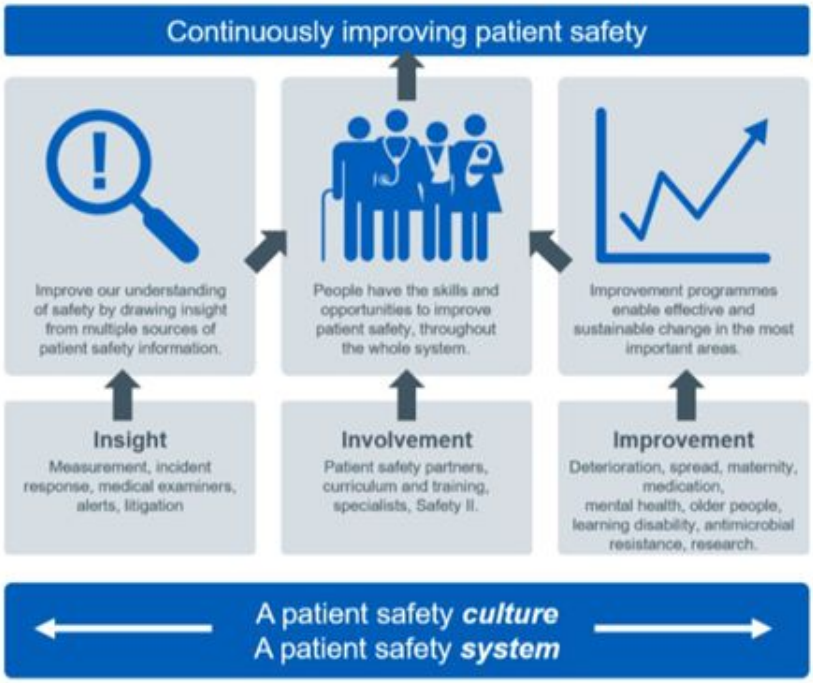
Actions to support

- Use metrics e.g. staff survey and other proxy indicators e.g. suspensions, anonymous incident reporting etc
- Focus on a just culture - adopt the NHS Just Culture Guide
- Embed the principles of a safety culture within and across local system organisations, and align those efforts with work to ensure organisations adhere to the well-led framework.
- National patient safety syllabus
- Patient safety specialists

Patient safety system

- Workforce - capacity, capability, well-being, safety improvement, system solutions
- Regulation
- Digital and technology

Figure 1: Summary of the NHS Patient Safety Strategy



The Three Strategic Aims

Insight

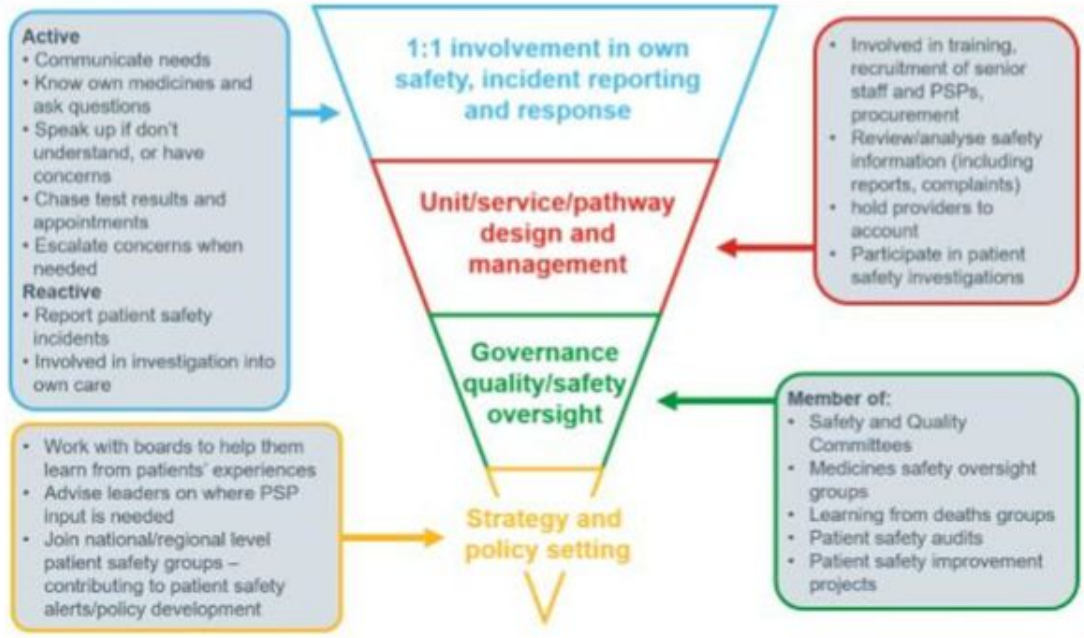
- Measurement
- New digital system to support patient safety learning - replacing NRLS and STEIS
- Patient safety incident response framework - will need to ensure implementation. Local systems will need to set out in their LTP implementation plans how they will implement the new PSIRF. Full implementation is anticipated by July 2021, informed by early adopter experience. Initially plans should:
    - identify PSIRF leads in local systems by Q4 2019/20
    - anticipate development of organisational-level strategic plans for patient safety investigation and review by the end of Q2 2020/21
    - ensure that leaders and staff are appropriately trained in responding to patient safety incidents, including investigation, according to their roles, with delivery of that training and development from end Q2 2020/21 onwards
    - eliminate inappropriate performance measures from all dashboards/performance frameworks by Q2 2020/21
    - as part of the organisation's quality governance arrangements, monitor on an annual basis the balance of resources for investigation versus improvement and whether actions completed in response to patient safety incidents measurably and sustainably reduce risk
- Healthcare Safety Investigation Branch (HSIB)
- Medical Examiner system - acute trusts in England to establish medical examiner offices to scrutinise the deaths occurring in their trust by end of Q4 2019/20. To ensure all deaths (in-hospital and community) are scrutinised by medical examiners by end Q4 2020/21

- National clinical review and response - NHS Improvement Patient Safety Alerts, National Patient Safety Alerts Committee. 100% compliance declared for all Patient Safety Alerts from Q2 2019/20
- Clinical negligence and litigation, including GIRFT litigation work stream
- GIRFT

Involvement

- Patient safety partners - patients, their families and carers, and other lay people. See below. The aim is for all safety-related clinical governance committees (or equivalents) in NHS organisations to include two PSPs by April 2021 and for them to have received required training by April 2022.

Figure 2: Potential roles of patient safety partners



- Patient safety education and training: the NHS should teach the workforce about safety - that error is normal and what the right approaches are to reduce risk and maximise the chances of things going well. HEE to develop a patient safety training plan for the NHS, educational programmes and competencies. Support all staff to receive training in the foundations of patient safety by April 2023

Figure 3: Potential modules for a national patient safety syllabus (from the Academy of Medical Royal Colleges patient safety syllabus)

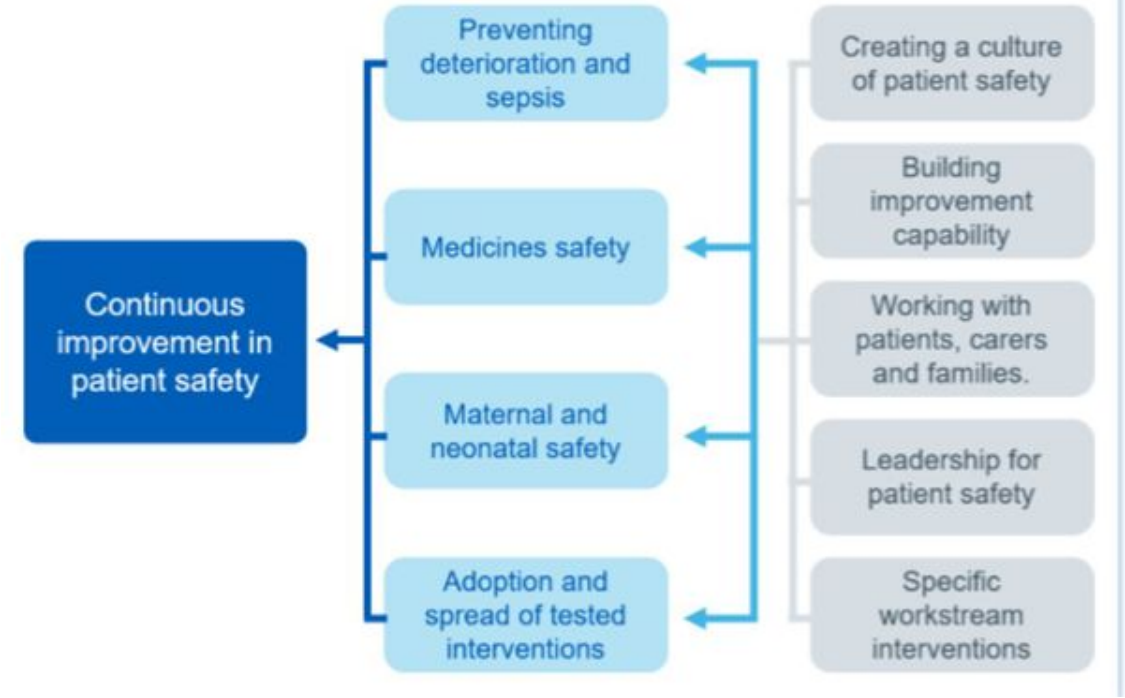
- Patient safety specialists - these will be key leaders within the safety system, visible to their organisations and others, able to support their organisations' safety work. Similar concept to designating someone a Caldicott Guardian, DIPC or Freedom to Speak Up Guardian but aim to develop existing people and roles rather than create new posts. NHS organisations to identify at least one person to be developed as their proposed patient safety specialist by April 2020 and to notify the national patient safety team who this person is. Release patient safety specialists for identified training by Q4 2021/22
    - Oversight of and provide support for patient safety activities across their organisations.
    - Ensure systems thinking, human factors and just culture principles are embedded in all patient safety activity.
    - Work closely with others, including medical device safety officers and medication safety officers
    - Support the fundamental principle that patient safety is everyone's responsibility – a specialist is not accountable for an organisation's safety on their own.

- Safety I and Safety II - in practice:
    - Study the system dynamics – for example, the way people adjust or make trade-offs to be able to continue to provide safe and good quality care when equipment or documentation is unavailable.
    - People need to know that the act of keeping patients safe is about having a constantly enquiring mind; noticing what happens every moment of every day; noticing when things go right; noticing when they could go wrong; and noticing when they do go wrong. They will then appreciate how they constantly adapt their behaviour and practice to work safely.
    - Conversations are important. Appreciative inquiry and learning from excellence create a more positive culture and provide meaningful positive feedback. Ask people who complete certain tasks every day how they get them done and what gets in the way of doing their daily work. They could report problems via an incident reporting system without waiting for an incident to happen; this can free up the whole process of learning as it will not be restricted by any reticence to report actual errors and harm.

Improvement

- National Patient Safety Improvement Programme
- Building on the work of the last five years, the revised national patient safety improvement programme (NPSIP), supported by the Patient Safety Collaborative (PSCs) across England that are commissioned through and hosted by the 15 Academic Health Science Networks (AHSNs), will be a key improvement and delivery arm of the NHS Patient Safety Strategy. National priorities for 2019/20:

Figure 4: Driver diagram for the NPSIP



Preventing deterioration and sepsis

NEWS2; 3 main domains of recognition, response and escalation. NPSIP will support local and regional approaches for adoption and spread across representative organisations for the following priority interventions:

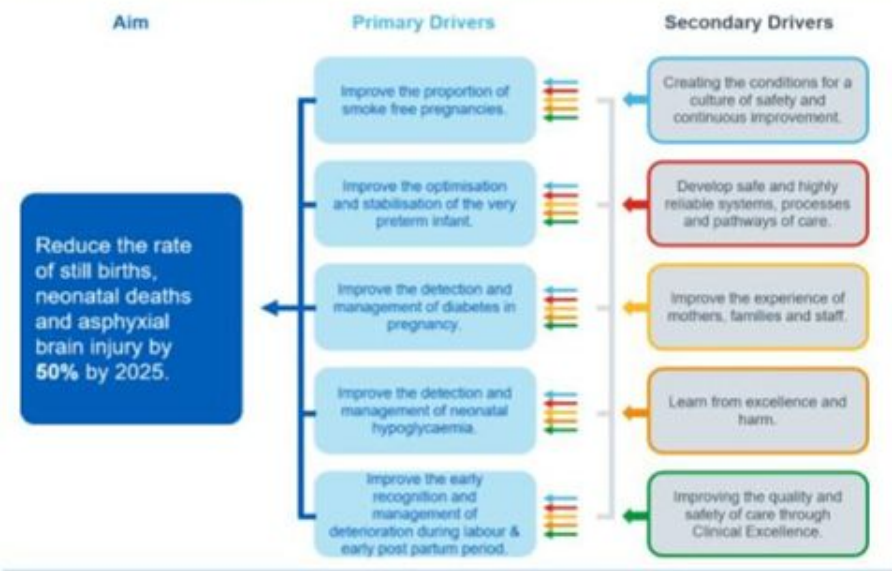
- emergency laparotomy care bundle - 87% patients benefitting from the care bundle by Q4 2019/20
- PReCePT - 33% increase in eligible mothers to whom MgSO4 is given by Q4 2019/20
- emergency department safety checklist - 50% increase in acute sites that benefit from the ED checklist or equivalent over baseline by Q4 2019/20
- chronic obstructive pulmonary disease (COPD) care bundle - 50% increase in sites that use the care bundle over baseline by Q4 2019/20
- NEWS2 adoption by all acute and ambulance trusts by Q4 2019/20

Maternity and Neonatal Safety Improvement Programme

The volume of insight being generated in maternity and neonatology will increase over the next few years with episodes of harm being investigated by multiple organisations (eg Each Baby Counts, HSIB, NHS Resolution and Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries – MBRRACE). This process will be simplified for organisations with the creation of a single portal for reporting episodes of harm. The programme will support the new elements in the Saving

Babies Lives Care Bundle (2019): **risk assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction, raising awareness of reduced foetal movement and some aspects of reducing preterm birth**.
Nationally reduce the rate of stillbirths, neonatal deaths and asphyxial brain injury by 50% by 2025

Figure 6: Driver diagram for the MNSIP



Medicines Safety Improvement Programme - priority projects:

- Develop an exemplar to illustrate best practice in transition of patients on anticoagulants from hospital to care home
- Improve drug administration safety in care homes through regular medication review
- Commission shared decision making (SDM) training for clinical pharmacists moving into PCNs, to work with patients with atrial fibrillation (AF) on anticoagulants
- SDM/self-management support for clinical pharmacists starting with people on opioids
- Enabling structured medicines reviews across an advanced STP/ICS starting with population at risk due to polypharmacy
- exemplars of best practice for transitioning patients with mental health needs
- tackling drug omissions, specifically antibiotics, insulin and anti-parkinsonian drugs
- maximising the benefits of an integrated pharmacy system to address frailty
- training in SDM around high risk medicines (e.g. insulin), patients or situations
- Inclusion of medicines management standards in digital standards for the shared record.

Safety issues that particularly affect older people

- Falls
- Pressure ulcers
- Nutritional care
- Safety of the interfaces

Safety and learning disabilities

- LeDeR is being accelerated and will be supported and aligned with the medical examiner system

- Expanding STOMP (Stopping Over Medication of People with Learning Disabilities) and STA (Supporting Treatment and Appropriate Medication in Paediatrics)
- Ask, listen, do - supports organisations to learn from and improve the experiences of people with a learning disability and their families and carers when they raise a concern or give feedback.
- Care and treatment reviews (CTRs) - encouraging people to find alternatives to hospital admissions where appropriate is important.
- All NHS-commissioned care will meet the learning disability improvement standards by 2023/24

Anti-microbial resistance (AMR) and healthcare-associated infections

- UK National Action Plan for AMR published Jan 2019
- NHS Right Care Urology Programme - commissioner activity to continue to improve safe and effective management of urinary tract infection (UTI) in primary care, reducing the risk of GNBSIs and inappropriate use of antibiotics in older people.
- GIRFT surgical site infection survey
- Promotion of vaccination against influenza etc
- Ongoing improvement in antimicrobial prescribing in secondary care - supported by upgrading EPMA systems and decision support tools. This will align with the Medication Safety Improvement Programme
- CQUIN 2019/20 - improvement in the diagnosis and treatment of lower UTI in older people in acute hospital care, ensuring adoption of PHE and NICE diagnostic and antimicrobial prescribing guidance, supported by the 'To Dip or Not To Dip' improvement toolkit.
- Local systems should develop plans to:
    - halve healthcare associated Gram-negative blood stream infections by 2024 (25% by 2021)
    - reduce community antibiotic use by 25% (from 2013/14 baseline) by 2024
    - reduce use of 'reserve' and 'watch' antibiotics by 10% by 2024 from 2017 baseline
    - improve the management of lower UTI in older people in all care settings by Q4 2019/20 (supported by CQUIN)
    - improve antibiotic prophylaxis for colorectal surgery by Q4 2019/20 (supported by CQUIN

Research and innovation

The National Institute for Health Research (NIHR)-funded Patient Safety Translational Research Centres (PSTRCs) will pull advances from basic research of potential relevance to patient safety into early pilot/feasibility clinical, applied and health services research of relevance to patient safety. This collaborative type of research aligns closely with the philosophy of human-centred design, which focuses on the creation of innovations based on science and rooted in reality and human factors.

A jointly convened meeting of Improving Patient safety Steering Group and Human factors Group will take place early in the New Year in order to decide on priorities for implementation that will be recommended to the Trust.

6. Incident reporting update:

The latest 6 monthly report from the National Reporting and Learning System (NRLS) has been received. A link is provided below. It demonstrates a change in the right direction- more events reported and more no harm with less moderate. We need to now do the analysis to work out where we fit compared with benchmarked Trusts and England's best.

https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-25-September-2019/

7. Consultant appointments.

The planned AAC for Acute Medicine has been re-scheduled due to the personal circumstances of the applicant. The Directorate remains hopeful of a successful appointment.

An AAC for urology is planned for December 4th. The single applicant looks very promising.

Harrogate and District NHS Foundation Trust

Date of Meeting:	27 November 2019	**Agenda item:**	
Report to:	Board of Directors		
Title:	Learning from deaths report Q2 2019/20		
Sponsoring Director:	Dr David Scullion, Medical Director		
Author(s):	Dr Sylvia Wood, Deputy Director of Governance		
Report Purpose:	**Decision**	**Discussion/ Consultation** ✓	**Assurance** ✓ **Information** ✓
Executive Summary:	During Q2 2019/20 seven structured judgement reviews (SJRs) were completed with one case referred for a second review. 71% (5/7) patients reviewed had good or excellent overall care. 25/33 (76%) phases of care were rated as good or excellent. Concerns about overall care were identified in two cases and second reviews are completed for one and expected for the other. A third case had poor care identified on admission and during the initial management but otherwise care was excellent and the outcome unlikely to have been affected. The deaths of three patients with learning disabilities were reviewed. In 2 of these cases the care was good or excellent overall. The third case was one of the 2 cases with poor care overall. These cases are also referred to the national Learning Disabilities Mortality Review (LeDeR) programme. The structured judgement reviews also contained descriptions of good and excellent care and practice. The report also includes an update about LeDeR and actions relevant to the care of people with learning disabilities. Information about the process for reviewing deaths in neonates and paediatrics has been included in this report; the process for reviewing stillbirths, neonatal deaths and maternal deaths was included in the last report to the Board and has not been repeated. The Q2 report of post cardiac arrest case note reviews was not available and will in included in the next quarterly update. The report is discussed at the Improving Patient Safety Steering Group and End of Life Operational Group to agree any actions, and to ensure themes and learning is shared appropriately across the organisation.		

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Related Trust Objectives					
To deliver high quality care	✓	**To work with partners to deliver integrated care:**	✓	**To ensure clinical and financial sustainability:**	✓

Key implications	
Risk Assessment:	The learning from deaths process aims to identify areas where improvements can be made to patient care which will reduce clinical risk.
Legal / regulatory:	There is a requirement to collect and publish specified information on deaths including learning points every quarter with a paper and agenda item to public Board meetings from Q3 2017/18 onwards.
Resource:	There is a time resource required to undertake the case note reviews, data collection and analysis.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	HDFT Learning from Deaths Policy
Assurance:	Learning from quarterly reports are reviewed at the Improving Patient Safety Steering Group and End of Life Operational Group.

Action Required by the Board of Directors:

It is recommended that the Board of Directors
:

- **Notes** items included within the report and the current processes for ensuring learning from deaths.

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Introduction

For those patient deaths meeting the criteria for a detailed review of case notes, the Medical Director appoints a clinician with appropriate expertise to undertake a structured judgement review (SJR). Whenever possible, the clinician will not have been involved in the care of the patient who died. A case note review is to determine not only examples of good practice, but also whether there were any problems in the care provided to the patient who died in order to learn from what happened.

The Trust has adopted the RCP National Mortality Review Tool which is hosted on Datix. This enables easy access to the information gathered but is not an easy tool for reporting and there is some potential for error when historic cases are being reviewed at the same time as current cases.

All structured case note reviews undertaken during Q2 2019/20 have been included in this report.

All hospital cardiac arrests are reported to the National Cardiac Arrest Audit (NCAA) to monitor and report on the incidence of, and outcome from, in-hospital cardiac arrest in order to foster improvements in the prevention, care delivery and outcomes from cardiac arrest. It is a joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre) and is included in the Department of Health Quality Accounts. Further learning is sought by case notes reviews of all in-hospital cardiac arrests which are reviewed by the Resuscitation Committee to identify any areas of learning to share and determine whether the resuscitation is deemed appropriate or inappropriate; this information for Q2 was not available and will be included in the Q3 report.

The report also includes updated information about the LeDeR Programme, and a description of the process for reviewing and learning from deaths in neonates and paediatrics.

Results

Structured case reviews

Summary of inpatient deaths and structured case note reviews

The table below shows the number of inpatient deaths by quarter since 2017/18, and the number of structured judgement reviews (SJRs) undertaken since 2014/15, by the year in which the review was undertaken and the year and quarter in which the death occurred. During 2018/19 60 SJRs were undertaken, 31 related to deaths during 2017/18 and 29 related to deaths during 2018/19.

During Q1 2019/20 11 SJRs were undertaken, 9 related to deaths during 2018/19 and 2 related to deaths during Q1 2019/20. During Q2 2019/20 7 SJRs were undertaken, 3 related to deaths during 2018/19 and 4 related to deaths in 2019/20.

		Quarter or year in which the death occurred																
					2017/18					2018/19					2019/20			
		2014/15	2015/16	2016/17	Q1	Q2	Q3	Q4	2017/18	Q1	Q2	Q3	Q4	2018/19	Q1	Q2	2019/20	
	No of inpatient deaths				145	140	167	205	657	142	140	177	182	641	177	139	316	
																		Total undertaken
Number of structured judgement reviews (SJRs)	SJRs previously reported	4	27	40	3	8	14	6	31	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a	102
	Total SJRs undertaken during 2018/19 by year of death								31					29	N/a	N/a	N/a	60
	Total SJRs undertaken during Q1 2019/20 by year and Q of death										2	3	4	9	2	N/a	2	11
	Total SJRs undertaken during Q2 2019/20 by year and Q of death											1	2	3	2	2	4	7
	Total number of SJRs undertaken relating to deaths in the period	**4**	**27**	**40**					**62**	0	2	4	6	**41**	**4**	**2**	6	**180**

Assessment of care

The table below shows the assessment of care for the identified stages of care provision for each of the seven case reviews completed during Q2. 71% (5/7) patients reviewed had good or excellent overall care. The care is rated for each of up to seven phases or elements of care. Out of 49 possible phases or elements of care, 16 were not applicable, and 25/33 (76%) phases of care were rated as good or excellent.

Care scores summary 2019/20 Q2					
	Good or excellent care (score 4-5)	Average care (score 3)	Poor care (score 1-2)	N/a	Total
Admission and initial management	4	0	3	0	7
On-going care	5	1	0	1	7
Care during procedure	0	0	0	7	7
Peri-operative care	0	0	0	7	7
End of life care	6	0	0	1	7
Overall assessment of care received	5	0	2	0	7
Overall assessment of patient record	6	0	1	0	7

Concerns about overall care were identified in two cases.

1. A second review was undertaken by Dr Matt Shepherd and learning shared. This included:
    a. All patients that are returning after discharge (or self-discharge) must be seen by an ED doctor and if being considered for direct return to a ward there must be a doctor to doctor handover prior to patient moving. This was implemented immediately after the case happened.
    b. Individuals concerned reflected on their lack of documentation and on the case in general.
2. Awaiting second review.

The third case with poor care identified on admission only was described as showing poor documentation in the first few hours and suboptimal care during the initial management. However, for the most part, care was excellent and the outcome unlikely to have been altered in this case. The patient was reviewed extremely regularly by both junior and senior medical staff. Decisions regarding ceilings of care were made appropriately and discussion and communication with family members was excellent. Documentation on the wards was excellent.

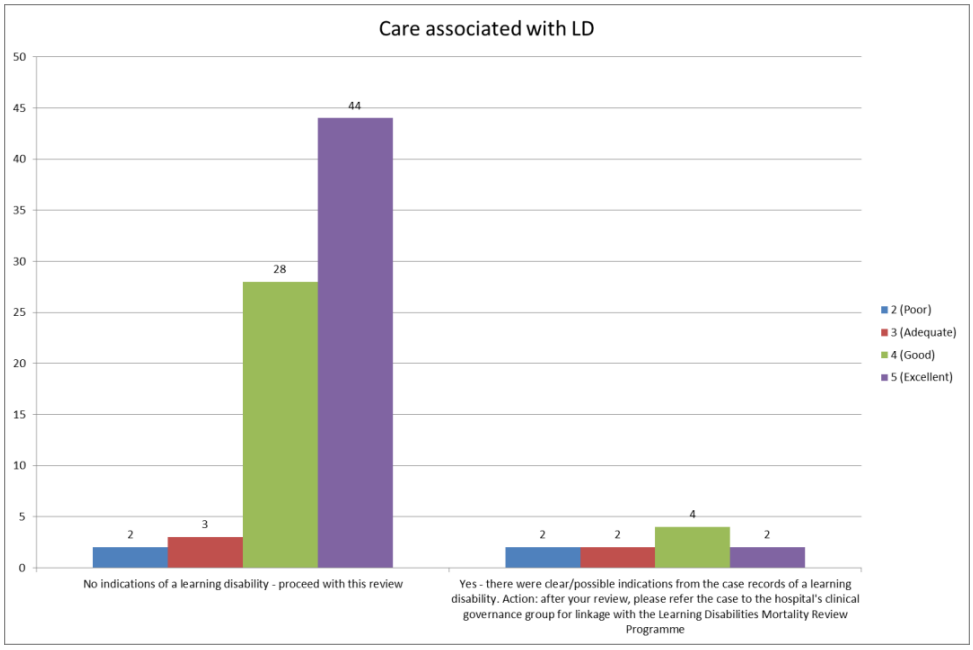
Problems with care

The SJR proforma has a section that enables the identification of problems in care. No problems in care were identified in 4/7 cases in Q2. Three cases were identified as having problems in care and in one case this was thought to have resulted in harm. The second review is awaited.

Problems with care: 2019/20 Q2				
	Degree of harm if problems identified			Total
	No harm	Uncertain harm	Harm	
No problems with care identified				4
Problems in care identified	1	1	1	3
Total				7

Deaths of patients with learning disabilities

There were three deaths of patients with learning disabilities during Q2 and all underwent a SJR. In 2 of these cases the care was good or excellent overall. The third case was one of the 2 cases with poor care overall and this was confirmed by a second review. These cases are also referred to the national Learning Disabilities Mortality Review (LeDeR) programme.



This table shows the overall care score for all reviews documented on the Datix mortality platform by whether the patient had learning disabilities or not. This suggests that we could improve the care of people with learning disabilities who die under the care of HDFT.

Results of LeDeR reviews

The Learning Disabilities Mortality Review (LeDeR) Programme is delivered by the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

The LeDeR Programme aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially modifiable factors associated with a person's death, and works to ensure that these are not repeated elsewhere.

We are required as a Trust to notify LeDeR of any deaths in our care of patients who were known to have learning disabilities. A notification system has been established which generates an automatic email to the Acute Liaison Nurse, Named Nurse for Adult Safeguarding and the Medical Director when the death of a patient flagged as having a learning disability is recorded on ICS. This prompts the LDLN to submit a notification to the LeDeR programme and the Medical Director to coordinate a Structured Judgement Review. In the period 2018/19 we notified the programme of 5 deaths. In Q1 2019/20 we notified the programme of four deaths and a further one death in Q2.

The findings of the multiagency review arranged by the LeDeR programme regarding a patient that died following an inpatient episode at HDFT during 2018/19 were included in the last report, as were the recommendations of the 2017/18 LeDeR report available from http://www.bristol.ac.uk/sps/leder/, and local actions taken as a result. Ben Haywood-Noble, HDFT Acute Liaison Nurse for Learning Disabilities and MCA developed a summary of the findings of the Learning Disabilities Mortality Review Programme, and a poster for all wards and departments to share learning from the LeDeR report. These are included below. Any situations where 'learning disabilities' including autism are documented as a rationale for a DNACPR order are raised with individual clinicians to ensure any unconscious bias is addressed.

Summary of the findings of the Learni

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Learning Lessons from the Learning Disabilities Mortality Review Programme

Introduced in 2016, the Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.
The programme is the first national programme of its kind in the world. Its overall aims are to:

- Support improvements in the quality of health and social care service delivery for people with learning disabilities.
- Help reduce premature mortality and health inequalities for people with learning disabilities.

In over 50% of cases the care and treatment provided fell short of good practice. In 4% of cases poor quality care directly contributed to the patient's death.

In 108 cases, there were delays in care and treatment that adversely affected the patient's health. These included investigations not being carried out.

Constipation affects up to 50% of people with LD. In 2018 a person died from being constipated. Nobody should die from constipation.

In 19 cases, there was a DNACPR in place where 'learning disabilities' or 'Down's syndrome' was inappropriately documented as the reason to not resuscitate

What are we doing?

- Engaging with local LeDeR reviewers
- Notifying deaths
- Communicating learning through a range of internal processes
- Raising awareness through LD link workers
- Provide LD training to all clinical staff

What can you do?

- Don't make assumptions about quality of life
- Listen to the patient and the people that know them well
- Make sure that your learning disability training is up to date
- Contact the Learning Disability Liaison Nurse if you need support or advice

You matter most

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Learning from neonatal and paediatric deaths

Neonates

This has changed since the beginning of this year; there is both an external and an internal process. All deaths are referred externally to Healthcare Safety Investigation Branch (HSIB). All will be investigated and an external report produced looking at both obstetric factors and paediatric factors. Lessons learned are fed back to the department. All such deaths will be discussed with the Coroners Officer and they will nearly always have a post mortem. Internally all deaths are reported on Datix and all will be discussed at the perinatal morbidity and mortality meeting. This is attended by both paediatric and obstetric staff. If there were any significant issues of concern raised at any point of either process, this would be raised with the Risk Management Department or Complaints and Risk Management Group (CORM).

Paediatrics

All paediatric deaths within the hospital are reported on Datix. If there were any significant issues of concern this would be raised with the Risk Management Department or CORM. All will be discussed with the Coroners Officer as deaths within the hospital will nearly always require a post mortem. All are presented and discussed at the monthly Paediatric Clinical Governance Meeting.

Sudden infant death syndrome (SIDS), suicides, other out of hospital deaths

The police will be involved and again all should be reported on Datix. The necessary investigations agreed with the child death overview panel (CDOP) and the local Coroner will be carried out in ED. All will require a post mortem and all are presented and discussed at the monthly Paediatric Clinical Governance Meeting. We will often not get the final post mortem report until 8-12 months after the event. CDOP will feed back any issues of concern from their perspective. Our paediatricians have quarterly meetings with them to discuss all cases.

Expected deaths in the community tend to be in Martin House Hospice. These will not be reported on Datix and not discussed at the Paediatric Clinical Governance Meeting unless the consultant looking after the child feels that there is anything to be learned from the case.

Reflection and learning identified

The numbers of deaths in hospital that can be unequivocally shown to be truly avoidable are fortunately rare. The mortality review process however provides a rich seam of learning which, albeit not necessarily affecting outcomes, will allow us to improve end of life care for many patients. The SJRs continue to emphasise the frailty and complexity of medical elderly patients in particular, and confirm the excellent care received by the great majority of patients whose death in hospital is expected.

The specific learning points identified during this process in Q2 2019/20 include:

- Implementation of the requirement for all patients returning after discharge (or self-discharge) to be seen by an ED doctor, and if being considered for direct return to a ward there must be a doctor to doctor handover prior to patient moving.
- Individuals concerned with cases of concern have reflected on their lack of documentation and the case management in general.
- Highlighting the importance of:
  - Good medical handover.
  - Ensuring investigations are carried out as planned on post take ward rounds, with follow up of these at senior review.
- Continuing to share and embed the learning identified from ongoing review of deaths of people with learning disabilities.

These learning points will be shared with staff in the #ChatterMatters newsletter.

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Date of Meeting:	27 November 2019	Agenda item:	5.6
Report to:	Board of Directors		
Title:	Nurse and Midwifery (Safe) Staffing Assurance Report		
Sponsoring Director:	Mrs Jill Foster, Chief Nurse		
Author(s):	Mrs Jill Foster/ Mrs Alison Mayfield, Deputy Chief Nurse		
Report Purpose:	The purpose of this report is to provide information and assurance to the Trust Board in relation to nursing and midwifery (safe) staffing levels		

Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓

Executive Summary:	This report provides: • The Trust Board with assurance that nursing and midwifery staffing across the organisation is set at a level that is safe, enables delivery of high standards of care and is affordable • Assurance that HDFT is compliant with national reporting requirements • Response to the recommendations from the NHSI Nurse Staffing Review of HDFT's acute services

Related Trust Objectives

To deliver high quality care	✓	**To work with partners to deliver integrated care:**	✓	**To ensure clinical and financial sustainability:**	✓

Key implications	
Risk Assessment:	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 and BAF 13: risk of insufficient focus on quality in the Trust.
Legal / regulatory:	None identified.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.

Action Required by the Board of Directors:

- **Note** the content of review
- **Be assured** that nursing and midwifery establishment levels are safe and appropriate for all areas included in the report.
- **Be assured that** appropriate measures are being undertaken to strengthen planning, operational, quality and financial oversight of nursing and midwifery establishments

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Introduction

The purpose of this report is to provide an update to the Trust Board about the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations 2012, 2016), NHS Improvement(NHSI, 2018) and the Care Quality Commission (CQC). It also complies with the expectation of the Operational Productivity and Performance within the NHS in England report (2016) to use the Care Hours per Patient Day (CHPPD) methodology.

The report also complies with recommendations 4 and 7 of the NHSI Nurse Staffing Review Improvement Plan agreed by the Trust Board in January 2019.

Background

In July 2016, the National Quality Board updated its guidance for provider Trusts. The updated guidance set out revised responsibilities for Trust boards for ensuring safe, sustainable and productive nursing and midwifery staffing levels.

This updated NQB guidance 2016 identified three expectations that form a triangulated approach to staffing decisions:

- **Expectation 1 Right staff**- evidenced based workforce planning, professional judgement, and peer comparison.
- **Expectation 2 Right skills**- training and development, working as multi professional team, recruitment and retention.
- **Expectation 3 Right place and time**- productive working and eliminating waste, efficient deployment and flexibility, efficient employment and minimising agency.

In February 2016, Lord Carter of Coles published his report into Operational Productivity and Performance within the NHS in England. In this report, Lord Carter describes one of the obstacles to eliminating unwarranted variation in nursing and care staff distribution across and within the NHS provider sector as due to a single means of consistently recording and monitoring staff deployment. This led to the development of benchmarks and indicators to enable comparison across peer Trusts as well as inpatient wards through the introduction of Care Hours Per Patient Day (CHPPD) measure.

In November 2018 the Trust received the NHSI Nurse Staffing Review report for Harrogate. This report agreed the Trust had established safe nursing and midwifery staffing levels but made recommendations regarding improving governance arrangements. The recommendations included strengthening oversight from the Trust Board in agreeing nursing and midwifery staffing levels. In January 2019 the Trust Board approved the NHSI Nurse Staffing Review Improvement Plan which included the following recommendations

Recommendation 4

Review the Trust's compliance with national safer staffing recommendations from the National Quality Board, NHS Improvement and NICE. Review the reporting of this to the Trust Board to ensure that it is equipped fully to exercise its accountability in this regard

Recommendation 6

Establish more robust processes for involving sisters and charge nurses in setting and agreeing their budgets.

This report presents the 'safer staffing' position for our acute in-patients wards. In addition this report includes information about the nursing and midwifery establishments in departments and communities beyond the acute in-patients wards.

Safe Sustainable and Productive Staffing; Measurement and Improvement

The HDFT Trust board receives monthly actual versus planned nursing and midwifery staffing levels and CHPPD data as part of the IBR and monitors key performance indicators (KPI) of quality, safety and patient experience through KPI dashboards and reports. The Trust Board also receives regular updates through papers presented by the Chief Nurse and Director of Human Resources. Cost Improvement Plans (CIP) that may impact on staffing undergo a Quality Impact Assessment (QIA) undertaken by the senior directorate team and signed off by the Chief Nurse and Medical Director to ensure that the impact of initiatives are not detrimental to the quality of service delivered. The Trust Board is responsible for the oversight of establishing nursing and midwifery staffing establishments as part of the annual budget setting process (NQB Guidelines). Reviews of the agreed nursing and midwifery staffing levels are presented to the Trust Board every six months.

The Board also receives external reports and recommendations from the CQC and NHSI. HDFT Trust Board papers relating to nursing and midwifery staffing are accessible to the public. Incident reporting, via datix, is actively encouraged to report concerns regarding staffing levels and Freedom to Speak Up (FTSU) Guardian role is embedded in the organisation and is widely publicised with FTSU champions available across the organisation. Staff feedback is also sought through local and national staff surveys.

Patient, and carer feedback is actively sought through "Friends and Family" survey results and through Patient Voice Group, compliments, complaints, comments, and National Patient Surveys.

Care Hours Per Patient Day (CHPPD)

From May 2016 all acute Trusts with inpatient wards/units began reporting monthly CHPPD data to NHS Improvement. This was a recommendation of the Lord Carter Review (2016) and Trusts 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. This benchmark is one indicator to enable comparison across peer Trust to eliminate unwarranted variation in nursing and care staff distribution across and within the NHS.

HDFT has been publishing registered and unregistered nursing fill rates, actual versus planned for the inpatient wards since June 2014 as per the "Hard Truths" commitments associated with publishing staffing data regarding nursing, midwifery and care staff levels. This information is part of the public Trust Board information and is published on the Trust's website. The daily actual versus planned staffing numbers are displayed in the inpatient ward areas. Since May 2016 the Trust has also published monthly CHPPD data at the public Trust Board and on our website.

Actual v planned nurse staffing/CHPPD data for the inpatient wards at HDFT Sept 18-Oct 19

	Day				Night				% Fill Rate				Care hours per patient day		
	RN		CSW		RN		CSW		Day		Night				
Month	Planned	Actual	Planned	Acutal	Planned	Actual	Planned	Actual	RN	CSW	RN	CSW	RN	CSW	Overall
Sep-18	28623.75	26493.75	18127.5	17962.5	16652.5	15951.25	8558	9116.25	92.6%	99.1%	95.8%	106.5%	4.8	3.1	7.9
Oct-18	29796.75	28173.75	18472.5	18547.5	17236	16713	8783.5	9086	94.6%	100.4%	97.0%	103.4%	4.9	3.0	7.9
Nov-18	29112	28042.43	18112.5	17741.25	16768	16473.75	8250	9278.5	96.3%	98.0%	98.2%	112.5%	4.7	2.9	7.6
Dec-18	30001.5	28380	18757.5	18450	17406.5	17231.75	8629.5	9641.5	94.6%	98.4%	99.0%	111.7%	4.8	3.0	7.8
Jan-19	30360.75	29285.625	18780	18862.5	17368	17533	8695.5	9524.9	96.5%	100.4%	101.0%	109.5%	4.9	3.0	7.9
Feb-19	27465	26280	17010	17118.75	15722	15856.75	7854	8750.5	95.7%	100.6%	100.9%	111.4%	4.9	3.0	7.9
Mar-19	30321	29088.75	18832.5	18862.425	17406.5	17441.75	8695.5	9575.5	95.9%	100.2%	100.2%	110.1%	4.9	3.0	7.9
Apr-19	28972.5	27022.5	18450	18547.5	16515	16592	8745	9256.5	93.3%	100.5%	100.5%	105.8%	4.8	3.1	7.9
May-19	29916	27669.375	19297.5	18614.925	17065.5	17142	9036.5	9597.5	92.5%	96.5%	100.4%	106.2%	4.9	3.1	8.0
Jun-19	28506	26280	18652.5	17775	16515	15953	8745	9053.25	92.2%	95.3%	96.6%	103.5%	5.2	3.3	8.6
Jul-19	30078	26017.5	19297.5	18622.5	17065.5	16631	9036.5	9238.9	86.5%	96.5%	97.5%	102.2%	4.8	3.2	8.0
Aug-19	29481	25766.175	19297.5	18753.75	17065.5	16416	9036.5	10081.5	87.4%	97.2%	96.2%	111.6%	4.7	3.2	8.0
Sep-19	28485	25567.5	18675	18018.75	16515	15765.5	8745	9845.5	89.8%	96.5%	95.5%	112.6%	4.7	3.1	7.8
Oct-19	29418	26580	19297.5	19293.75	17065.5	16205	9036.5	9988.25	90.4%	100.0%	95.0%	110.5%	4.8	3.3	8.0

Expectation 1 - Right Staff

Inpatient wards

Nurse staffing reviews at HDFT have all featured strong engagement of professional leaders including ward managers, matrons and Heads of Nursing.

As part of the budget setting process for 2019/20 the Chief Nurse met with each ward manager, matron and Head of Nursing to discuss the proposed nurse staffing budgets for the financial year, taking into account professional judgement, KPI's and recent dependency study results. All ward managers agreed they had been involved in the budget setting for their areas for 2019/20 and were satisfied the budget gave an establishment that enabled delivery of service and standards for their areas. There are times when the acuity and dependency of patients exceed planned staffing levels and wards require additional support.

Principles for adult inpatient ward nurse staffing establishments at HDFT

- Professional judgement, Registered Nurse to patient ratios, skill mix, key performance indicators and the use of evidence based tools are used to guide decision making with regard to nurse staffing levels at HDFT.
- Ward managers have between 1-3 supervisory days factored into establishments on the adult in patient wards.
- All wards have 1.00 wte band 7 ward manager supported by band 6 sister/charge nurses
- Each ward has a ward clerk.
- Some wards have a nutritional assistant
- Headroom uplift to establishments per ward which includes annual leave 14.96%, Study leave 1.92%, Sickness 3.9%. **Total 20.78%.**
- Capacity to provide some enhanced care requirements

The general ward establishments do not include:

- Further enhanced care requirements
- Winter pressures funding
- Maternity leave cover for staff (which is currently accommodated through a central resource which enables backfill)

Nursing dependency/Acuity studies

Adult inpatient wards-Nurse staffing tools (acuity tools) have been used to support decision making regarding required staffing levels for the adult inpatient wards. At HDFT we use the Safer Nursing Care Tool (SNCT) for the adult inpatient wards in conjunction with professional judgement, patient feedback, patient safety incidents and key quality indicators to determine staffing requirements.

The nursing dependency study is undertaken twice a year across the adult inpatient wards and the results can be seen in Appendix 1, which gives the results of the last four studies undertaken. It details the ward establishments at the time of the study, the average recommended establishment based on the results of the study and ward activity data. Data on the average number of empty beds per day has been added to reflect bed occupancy for the period of the study. To note nutritional assistant posts and discharge coordinators are not included in the total ward nursing establishment figures.

Paediatrics- In paediatrics we currently audit staffing levels against the RCN "Defining Staffing Levels for Children and Young People's Services.

Maternity- In Maternity we use the Birth-rate Plus acuity tool

Expectation 2 - Right Skills

The Trust discusses nursing recruitment in a number of forums, including the Directorate Resource Review meetings, Workforce and OD Steering Group, Partnership Forum and the Recruitment and Retention Group. From this an understanding of areas of shortage is gained. The HDFT Clinical Workforce Strategy 2016-2021 details our plans for future workforce transformation developing a pipeline of talent to ensure we can deliver sustainable safe and effective care.

Last year saw the introduction of the "RCN Clinical Leadership Programme" for Senior Nurses and AHP s and the First line Leader programme for all HDFT staff commenced in September 2019

Preceptorship -The Trust has an established two year Preceptorship programme for newly qualified nurses. This has received positive feedback. This is facilitated by the Practice Educators.

Global Learners Programme -The Trust is working in partnership with HEE as part of the Global Learners Programme. Through this programme the Trust has supported 28 Global Learners to date to obtain their NMC registration and more nurses are planned to join us in the next few months. The nurses are working in the wards, ED and Theatres

International Nurse Registration Programme. We have recently commenced the International Nurse Registration Programme (These are international nurses who are currently employed at HDFT as CSW who are applying for NMC registration and are receiving training to pass their OSCE.) 2 nurses have currently started this programme at HDFT.

Trainee Nurse Associate Programme . The current Registered Nurse (RN) recruitment challenges continues to drive an increase in temporary workforce spend. In response the Trust agreed to support the modernisation of the nursing workforce through the introduction of the Registered Nursing Associate (RNA) role to: reduce future reliance on temporary workforce, provide a richer skill mix to improve patient care and offer a new career opportunity for the non-registered workforce. RNA's are new NMC regulated roles that have a defined scope of practice which complements the RN role to ensure the continued delivery of safe high quality care by practitioners who are regulated professionals.

The Trust established a Trainee Nurse Associate (TNA) programme January 2018

- Cohort 1 has 9 trainees who will qualify in January 2020
- Cohort 2 has 8 trainees who will qualify in January 2021
- Recruitment is in progress for a 3rd TNA Cohort of 8 trainees, to commence January 2020, for completion in January 2022.

The Advanced Clinical Practitioner (ACP) programme- has seen eight members of staff qualify to date with a further four in training due to qualify in January 2020.

Nursing recruitment events are held regularly throughout the year.

Expectation 3 - Right Place and Time

Three times a day (more if necessary) senior staff, including Heads of nursing, matrons, clinical site coordinators and general managers meet to review patient flow and staffing levels in order to maintain at least minimum safe staffing in all areas. This is achieved but is extremely challenging on some occasions. The Trust has a minimum standard, whereby no ward is left with fewer than two registered nurses/midwives on any shift. Staffing levels are assessed directly by confirming staff available on the day and by the matrons' assurance checklist. Factors that are taken into consideration before determining if a ward is safe, or not, include:

- The numbers, skill mix, capability and levels of experience of the staff on duty
- Harm rates and activity levels
- The self-declaration by the shift leader on each ward as to their professional view on the safety and staffing levels that day
- The physical layout of the ward
- The availability of other staff – e.g. Bank, students, supernumerary
- The balance of risk across the organisation

On a daily basis we continue to take action to mitigate the risk due to staffing gaps by

- Maximising effective rostering
- All shift gaps published at ward level
- Staffing gaps reviewed a minimum of twice daily and staff moved to minimise risk.
- Bed closures where feasible.
- Quality and safety is monitored regularly and concerns escalated
- Matrons rota provides out of hours support weekdays until 9pm and weekends 9-5pm. This is in addition to the site coordination team who provide 24/7 nursing presence.
- All RN shifts go out to NHSP, our nurse bank and selected agencies.
- Enhanced Care requests are risk assessed and discussed on a daily basis

For the departments and community services staffing gaps are monitored by the senior team leaders and action taken to optimise skill mix and mitigate risks due to staffing gaps.

Planned and Surgical Care –Departments (PSC)

- Main Theatres – An establishment review was completed against the theatre schedule and a deficit in the budget identified and corrected. Vacancies for main theatre as of October 2019 were RN-2.9wte and ODP -7.5wte this is an improved position for RN but not for ODP, s.
- Day Surgery Unit - RN 2.49wte vacancies and ODP 3.53wte vacancies, this is a worse position, in part, due to staff members reducing their contracted hours.
- Outpatients Departments - earlier in the year a review of several outpatient areas was undertaken and a further review of other OPD areas is currently in progress, these are Orthopaedic OPD, Ophthalmology and Optical Services.
- Maxfax – Staffing review in progress.
- Endoscopy – Staffing review was undertaken and a band 4 Nursing Associate model agreed and will commence in Jan 2020. Endoscopy has 1wte RN vacancy and 1wte Nurse Endoscopist vacancy.
- ITU – Staffing review planned

Planned and Surgical Care (PSC) -Ward establishment and vacancies Oct 2019

Name of Ward	RN Staffing Establishment (WTE)	CSW Staffing Establishment (WTE)	RN Current Vacancies (WTE) -	CSW Current Vacancies (WTE) -
Farndale	14.92	17.04	4.4	.40
Wensleydale	17.74	12.87	4.87	1.13
Littondale	20.32	12.04	2.57	+ .48 over
Nidderdale	20.32	15.24	2.01	.16
Harlow	11.51	3.46	1.01	0.46
ITU/HDU	31.53	2.9	4.83	0

4 RN to start in November across the PSC wards

Maternity update

The maternity unit has used the Birth-rate Plus acuity tool since the end of 2018. The tool provides the intelligence needed to be able to model midwifery numbers, skill mix and deployment and to inform decision making about safe services. It is based on an understanding of the time required to care for women, using NICE guidance and available evidence and best practice.
The acuity tool is completed 4 hourly on delivery suite; capturing data at the time by the delivery suite coordinator. On Pannal ward this information is completed 8 hourly by predicting activity for the next 6 hours (day) and 12 hours (night) by the midwife in charge.

The acuity tool supports safety action 5 of the NHS Resolution Maternity Incentive Scheme – year. 2 which states:

- A systematic, evidence-based process to calculate midwifery staffing establishment has been done
- The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during the shift) to enable oversight of all birth activity in the service. This information is reviewed on a monthly basis to ascertain if achievable. Recently the decision was made for women being induced to be cared for on Pannal ward and not delivery suite to reduce the activity on the ward and enable the coordinator to be supernumerary.

Midwifery staffing establishment (October 2019)

Midwives	**Funded**	**In post**
Band 8B	1.0	1.0
Band 8A	1.0	1.0
Band 7	16.20	16.20
Band 6	46.02	46.25
Band 5	4.00	5.00
Total	**68.22**	**69.45**
Band 3	2.60	2.60
Band 2	10.24	10.20
Total	**12.84**	**12.80**

There is a temporary over establishment of midwives at the moment due to midwives returning from maternity leave and those going on maternity leave. This will improve in the New Year.

Assurance that staffing levels are safe
There are a number of ways we gain assurance that the staffing levels are safe;

- 1:1 care in labour – for January – September = 98% (aim for 100%, NHS Resolution)
- Midwife : Birth ratio – currently for July – September = 1: 28.09 (in post) and 1:28.91 (funded) (gold standard is 1:28.5)
- Use of the hospital midwife on call – is regularly reviewed – numbers of times required and reasons why
- A weekly review of datix forms completed for workload and staffing reasons
- Use of the Birth-rate + acuity tool (information within the reports and any key themes identified as well as monitoring of red flag events)
- Bi-annual staffing report as part of the NHS Resolution Maternity Incentive Scheme
- Safer staffing levels collected monthly
- Monitoring staff sickness levels – short and long term and reasons for sickness.

- Themes identified from concerns and complaints
- Review of FFT narrative comments – staffing concerns.
- Recent receipt of the Picker maternity survey 2019 – including narrative comments
- There is a new process for maternity safety concerns – an e mail address is now in place and monthly walkabouts for HOM/Matron and Chief Nurse. No safety concerns have been highlighted.

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Women's unit

The unit provides dedicated facilities for nurse and medical colposcopists and hysteroscopists providing a range of out-patient services for women.

Post	Planned	Actual
8a	3.00	1.51
7	0.00	0.00
6	0.00	2.00
5	1.60	1.60
2	1.00	1.00

Long Term and Unscheduled Care (LTUC)

Establishments and vacancies for the medical wards, SROMC & ED- Oct 2019

	RN Establishment wte	RN Vacancy wte	CSW Establishment wte	CSW Vacancy wte
SROMC	16.72	0	8.89	0
ED	34.73	5.68	11.22	0
Byland	18.04	4.5	21.12	2.62
Granby	13.47	0.9	12.51	+1.69
Jervaulx	18.04	5.5	21.12	0.61
Lascelles	11.76	0	10.68	1.74
Oakdale	19.92	1.69	20.39	5.5
Trinity	12.01	3.05	13.27	3.04
MSS	24.27	1.49	15.65	2.11
MAU	26.03	5.35	17.72	+1.69

Community Care Teams- LTUC

Establishment and vacancies Community Care Teams- LTUC Oct 2019

	RN establishment wte	RN vacancy wte	CSW establishment wte	CSW vacancy wte	Caseload
Harrogate North	12.3	0.43	7	0.5	336
Harrogate South	13.6	0	7.6	0	336
Ripon & Rural	12.6	0.84	8	0	373
Kbro & BB	15.8	0.98	9	0.24	516

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Children's and County wide Community Care

Acute Paediatric Staffing - Approved staffing 2019-2020

	Woodlands establishment	SCBU establishment	Woodlands vacancies	SCBU vacancies
Band 7	0	1.0	0	0
Band 6	2.61	2.99	1.00	0
Band 5	15.98	8.49	1.5	0.61
Band 4	1.0	0.79	0	0
Band 2	6.64	1.00	1.0	1.00
Number of Beds/ cots	22 including CAU	7		

Woodlands
Band 2 on Woodlands also includes the Ward Clark,
Band 6 on Woodlands will increase to 6.13 WTE by dropping the band 5 numbers, therefore no increase in numbers just banding.

Nursing establishment is based on The RCN Defining Staffing Levels for Children and Young people's Services 2013 and British Association of Perinatal Medicine (BAPM). We use a dependency tool twice a year for general paediatrics based on the RCN defining staffing levels which states, bedside, deliverable hands-on care;

Children < 2 years of age 1:3 registered nurse:child, day and night.
Children > 2 years of age 1:4 registered nurse:child, day and night.

SCBU
January 2019 the Neonatal ODN assessed our SCBU with regards to staffing levels in line with BAPM guidelines and confirmed we were compliant.

SCBU slightly increased the Band 6 establishments after a Band 4 left and converted post to Band 2.

Health Visitors and School Nurses establishments and vacancies October 2019

School Nurses

	Date	Oct-19
N Yorkshire	Budgeted Establishment	14.69
	Actual Establishment	16.69
	(Over) / Under Establishment	-2.00
Darlington	Budgeted Establishment	7.65
	Actual Establishment	5.95
	(Over) / Under Establishment	1.70
Middlesbrough	Budgeted Establishment	6.66
	Actual Establishment	7.25
	(Over) / Under Establishment	-0.59
Durham	Budgeted Establishment	26.48
	Actual Establishment	22.91
	(Over) / Under Establishment	3.57
Stockton	Budgeted Establishment (Based on Bid)	4.00
	Actual Establishment	6.84
	(Over) / Under Establishment	-2.84
Sunderland	Budgeted Establishment (Based on Bid)	5.00

Actual Establishment	5.53
(Over) / Under Establishment	-0.53

Gateshead

Budgeted Establishment (Based on Bid	5.00
Actual Establishment	5.03
(Over) / Under Establishment	-0.03

Overall Total

Budgeted Establishment	69.48
Actual Establishment	70.20
(Over) / Under Establishment	-0.72

Health Visitors

N Yorkshire

Date	Oct-19
Budgeted Establishment B6	74.88
Actual Establishment	77.25
(Over) / Under Establishment	-2.37

Darlington

Budgeted Establishment	20.36
Actual Establishment	20.16
(Over) / Under Establishment	0.20

Middlesbrough

Budgeted Establishment	38.69
Actual Establishment	37.10
(Over) / Under Establishment	1.59

Durham

Budgeted Establishment	105.00
Actual Establishment	105.33
(Over) / Under Establishment	-0.33

Stockton

Budgeted Establishment (Based on Bid)	31.00
Actual Establishment	27.11
(Over) / Under Establishment	3.89

Sunderland

Budgeted Establishment (Based on Bid)	59.89
Actual Establishment	56.14
(Over) / Under Establishment	3.75

Gateshead

Budgeted Establishment (Based on Bid)	39.00
Actual Establishment	37.73
(Over) / Under Establishment	1.27

Overall Total

Budgeted Establishment	368.82
Actual Establishment	360.82
(Over) / Under Establishment	8.00

Conclusion

Nursing, Midwifery and Health Visitor staffing remains challenging on a daily basis both in the hospital and across the community children's and adult teams. This paper has detailed how this risk is managed and how our workforce plans have been designed to help reduce our current vacancy position.

The Nursing and Midwifery staffing establishments are set and funded to a good standard which allows delivery of high quality care in all services and maintains patient flow throughout the acute services. Staffing levels will continue to be reviewed twice a year by the Trust Board in line with national guidance.

Jill Foster

Chief Nurse

November 2019

References

National Quality Board (2012) How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability

National Quality Board 2016 Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe, sustainable and productive staffing

NHS Improvement (June 2018) Care Hours Per Patient Day (CHPPD) Guidance for acute and acute specialist trusts

Operational productivity and performance in English NHS acute hospitals: Unwarranted variations (2016) – An independent report for the Department of Health by Lord Carter of Coles

Appendix 1: Safer Nursing Care Tool Data 2018 and – 2019

Summary of safer nursing care tool data - July/Aug 2019

		Staffing levels indicated by tool			Average daily totals reported:											
Ward	Ward * Establishments	Average of all days	Maximum daily requirement	Minimum daily requirement	Empty Funded Beds	Acute Admissions	Elective Admissions	Discharges	Transfers In	Transfers Out	Ward attenders	Deaths	Escorts on Site	Escorts off Site	Number Patients requiring 1-1 care	Patient Outliers
MAU	42.25	38.17	46.18	18.23	6.00	19.19	0.00	8.71	0.19	6.95	0.19	0.00	0.14	0.00	0.24	0.00
MAU Escalation		Data not complete July/Aug 2019			MAU Escalation patient flow data not complete for July/Aug 2019											
Byland		Data not complete July/Aug 2019			Data not complete for July Aug 2019											
Farndale	31.96	26.72	39.13	11.47	4.67	0.38	0.05	0.90	0.24	0.33	0.00	0.00	0.00	0.00	0.00	0.86
MSS		Data not complete July/Aug 2019			Data not complete for July Aug 2019											
Granby	24.98	15.92	18.04	11.55	1.14	0.24	0.05	2.57	1.76	0.00	0.90	0.10	0.00	0.00	0.00	0.00
Harlow	14.97	8.30	10.90	5.87	1.67	2.14	1.24	3.10	1.14	0.05	0.10	0.00	0.00	0.00	0.00	0.00
Jervaulx	37.76	47.25	50.26	34.97	1.71	2.14	0.00	2.14	0.76	0.00	0.05	0.14	0.00	0.00	7.48	0.05
Littondale	31.36	22.23	29.79	16.36	11.05	0.29	0.19	7.05	3.86	0.62	0.10	0.05	0.00	0.00	0.19	0.90
Nidderdale	34.53	28.29	33.69	22.73	5.29	2.95	0.48	7.10	3.95	0.71	3.19	0.10	0.00	0.00	0.95	0.24
Oakdale	39.31	29.46	35.65	20.95	7.52	2.90	0.00	1.67	0.43	0.14	0.05	0.14	0.00	0.00	0.67	0.05
Trinity	25.28	28.29	0.00	0.00	3.57	1.19	0.00	0.62	0.29	0.05	0.00	0.05	0.00	0.00	#DIV/0!	0.00
Wensleydale	29.61	30.10	34.21	24.65	5.14	1.24	0.05	5.52	3.71	2.67	0.00	0.10	0.00	0.00	0.43	0.43
Wensleydale Escalation	0	Data not complete July/Aug 2019			Wensleydale Escalation patient flow data incorporate into Wensleydale base ward data											
Lascelles	22.44	19.38	20.65	17.97	-0.19	0.00	0.00	0.14	0.00	0.00	0.00	0.00	0.00	0.52	1.00	0.14
Swaledale	Ward not open during July/Aug 2019															

*Nutritional assistants, discharge coordinators and ward clerks are not included in the establishment numbers

Summary of safer nursing care tool data - March/April 2019

		Staffing levels indicated by tool			Average daily totals reported:											
Ward	Ward * Establishments	Average of all days	Maximum daily requirement	Minimum daily requirement	Empty Funded Beds	Acute Admissions	Elective Admissions	Discharges	Transfers In	Transfers Out	Ward attenders	Deaths	Escorts on Site	Escorts off Site	Number Patients requiring 1-1 care	Patient Outliers
MAU	42.25	40.89	60.65	18.23	3.00		0.48	8.57	0.76	7.62	0.14	0.19	0.29	0.00	0.14	0.00
MAU Escalation		Data not complete March/April 2019			MAU Escalation patient flow data not complete for March/April 2019											
Byland	38.56	45.25	50.02	24.27	1.52	0.62	0.00	2.86	1.43	0.24	0.00	0.43	0.00	0.00	2.00	0.00
Farndale	31.96	27.29	34.73	19.69	3.86	1.76	0.05	1.95	0.19	0.29	0.10	0.10	0.00	0.00	2.90	6.00
MSS	39.67	33.62	41.09	19.68	3.29	2.76	0.00	6.52	4.38	1.19	0.00	0.29	0.10	0.00	0.14	0.00
Granby	24.98	19.36	22.93	13.64	1.62	0.14	0.00	2.90	2.10	0.33	2.48	0.14	0.14	0.00	0.00	0.00
Harlow	14.97	8.33	9.78	5.87	1.90	1.76	0.95	2.57	1.10	0.29	0.24	0.10	0.00	0.00	0.00	0.00
Jervaulx	37.76	42.46	47.84	38.16	2.05	1.76	0.00	2.38	1.00	0.00	0.00	0.38	0.00	0.00	4.90	0.00
Littondale	31.36	26.47	31.49	16.36	8.71	0.52	0.05	4.38	2.48	0.71	0.05	0.10	0.00	0.00	0.43	0.14
Nidderdale	34.53	28.21	38.43	22.35	4.86	1.81	0.19	5.81	2.81	0.76	2.81	0.19	0.00	0.00	0.19	0.29
Oakdale	42.07	37.88	43.70	31.50	4.43	2.90	0.05	1.67	0.95	0.43	0.00	0.19	0.00	0.00	0.22	0.00
Trinity	25.28	28.21	0.00	0.00	0.81	0.57	0.00	0.86	0.14	0.05	0.00	0.00	0.00	0.05	0.00	0.00
Wensleydale	29.61	26.51	32.37	20.88	4.48	1.48	0.05	5.67	3.95	2.33	0.00	0.00	0.00	0.00	0.62	0.00
Wensleydale Escalation	0	0.09	0.98	-	Wensleydale Escalation patient flow data incorporate into Wensleydale base ward data											
Lascelles	22.44	18.13	19.43	15.31	0.43	0.10	0.00	0.24	0.05	0.05	0.00	0.00	0.00	0.00	0.00	0.00
Swaledale	Ward not open during March/April 2019															

*Nutritional assistants, discharge coordinators and ward clerks are not included in the establishment numbers

Summary of safer nursing care tool data - Jun/Jul 2018

		Staffing levels indicated by tool			Average daily totals reported:												
Ward	Ward * Establishments	Average of all days	Maximum daily requirement	Minimum daily requirement	Empty Funded Beds	Acute Admissions	Elective Admissions	Discharges	Transfers In	Transfers Out	Ward attenders	Deaths	Escorts on Site	Escorts off Site	Number Patients requiring 1-1 care	Patient Outliers
CATT	42.25	32.17	43.74	18.23	9.35	17.86	0.00	9.71	1.05	5.43	0.38	0.10	0.00	0.00	0.19	0.00
CATT Escalation		Data not complete February 2018			CATT Escalation patient flow data incorporate into CATT base ward data											
Byland	38.56	33.49	39.74	24.27	5.76	0.14	0.00	1.90	0.67	0.05	0.00	0.19	0.00	0.14	1.00	0.00
Farndale	31.96	27.39	34.81	20.73	4.33	1.05	0.00	1.57	0.19	0.14	0.00	0.05	0.00	0.00	0.29	2.14
AMU	39.67	33.14	39.93	19.68	4.40	2.38	0.00	4.86	2.95	0.95	0.00	0.38	0.43	0.05	0.00	0.05
Granby	24.98	20.50	23.84	15.48	1.14	0.10	0.05	1.81	1.10	0.10	2.10	0.10	0.05	0.05	0.48	0.00
Harlow	14.97	8.35	10.97	5.87	1.70	1.33	0.76	3.38	1.43	0.33	0.19	0.00	0.00	0.00	0.00	0.00
Jervaulx	37.76	46.91	50.26	40.14	1.43	0.14	0.00	1.81	0.86	0.10	0.00	0.24	0.00	0.00	0.00	0.00
Littondale	31.36	20.78	24.44	16.36	11.45	2.14	0.14	5.76	2.95	0.52	0.00	0.10	0.00	0.00	0.00	1.81
Nidderdale	34.53	20.75	24.26	17.02	9.81	2.24	0.33	4.57	1.67	1.05	1.71	0.05	0.00	0.00	0.14	2.00
Oakdale	42.07	36.42	45.21	26.40	4.76	1.14	0.05	2.10	0.81	0.33	0.00	0.14	0.00	0.00	2.10	0.05
Trinity	25.28	19.50	22.86	14.15	1.43	0.10	0.05	0.67	0.14	0.10	0.00	0.05	0.05	0.00	0.00	0.00
Wensleydale	29.61	25.93	31.86	14.55	5.29	1.14	0.00	5.29	3.29	2.76	0.05	0.05	0.00	0.00	0.00	0.05
Wensleydale Escalation	0	0.09	0.98	-	Wensleydale Escalation patient flow data incorporate into Wensleydale base ward data											
Lascelles	22.44	17.51	19.43	15.06	0.86	0.10	0.00	0.38	0.05	0.00	0.00	0.00	0.00	0.48	2.48	0.00
Swaledale	Ward not open during Jun/Jul 2018															

*Nutritional assistants, discharge coordinators and ward clerks are not included in the establishment numbers

**wef/ July 2018

Summary of safer nursing care tool data - Feb/Mar 2018

		Staffing levels indicated by tool			Average daily totals reported:											
Ward	Ward * Establishments	Average of all days	Maximum daily requirement	Minimum daily requirement	Empty Funded Beds	Acute Admissions	Elective Admissions	Discharges	Transfers In	Transfers Out	Ward attenders	Deaths	Escorts on Site	Escorts off Site	Number Patients requiring 1-1 care	Patient Outliers
CATT	42.25	Data not complete February 2018			1.88	16.29	0.05	7.29	0.86	5.57	0.19	0.29	0.57	0.00	1.05	0.00
CATT Escalation		Data not complete February 2018			CATT Escalation patient flow data incorporate into CATT base ward data											
Byland	38.56	40.95	46.16	34.91	0.67	0.29	0.00	1.90	0.86	0.05	0.00	0.24	0.00	0.00	2.86	0.00
Farndale	31.24	33.45	37.80	20.18	1.62	1.76	0.05	1.81	0.52	0.67	0.05	0.05	0.00	0.00	0.71	10.24
AMU	38.95	34.39	40.92	23.33	1.57	2.71	0.00	4.05	2.05	1.10	0.00	0.38	0.24	0.14	2.29	0.24
Granby**	24.98	26.45	0.00	0.00	-5.43	0.19	0.05	2.38	1.43	0.05	1.90	0.10	0.19	0.00	0.29	0.00
Harlow	14.97	9.40	11.22	7.56	0.81	0.67	0.86	2.33	0.95	0.57	0.05	0.05	0.00	0.00	0.00	0.00
Jervaulx	37.76	Data not complete February 2018			10.10	0.14	0.00	1.62	0.57	0.05	0.00	0.29	0.29	0.00	1.71	0.00
Littondale	32.76	30.30	38.97	20.23	4.86	4.52	0.43	6.19	1.71	1.29	1.76	0.24	0.00	0.00	1.05	8.10
Nidderdale	32.08	30.14	37.41	26.94	1.95	3.48	0.38	5.81	1.95	0.71	3.38	0.10	0.00	0.05	1.86	5.57
Oakdale	41.35	38.79	45.33	25.07	1.86	0.48	0.05	1.90	1.19	0.19	0.00	0.19	0.00	0.00	2.24	0.00
Trinity	25.28	Data not collected February 2018			N/A	0.05	0.00	0.48	0.05	0.05	0.00	0.10	0.00	0.00	0.00	0.00
Wensleydale	29.25	32.16	35.63	24.10	0.95	0.90	0.05	4.52	3.19	1.14	0.00	0.00	0.00	0.00	1.72	0.86
Lascelles	22.44	22.09	22.09	22.09	-1.00	0.05	0.00	0.29	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Swaledale		Data not collected Swaledale 2018			Data not collected Swaledale 2018											

*Nutritional assistants, discharge coordinators and ward clerks are not included in the establishment numbers

**Granby dependancy scores include 6 esclalation beds

Harrogate and District NHS
NHS Foundation Trust

ANNUAL INFECTION PREVENTION AND CONTROL REPORT 2018/2019

Dr Jenny Child MBBS MD FRCPath
Consultant Microbiologist & DIPC

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Harrogate and District NHS
NHS Foundation Trust

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2018/2019 dashboard summary, infections reported to national mandatory surveillance scheme

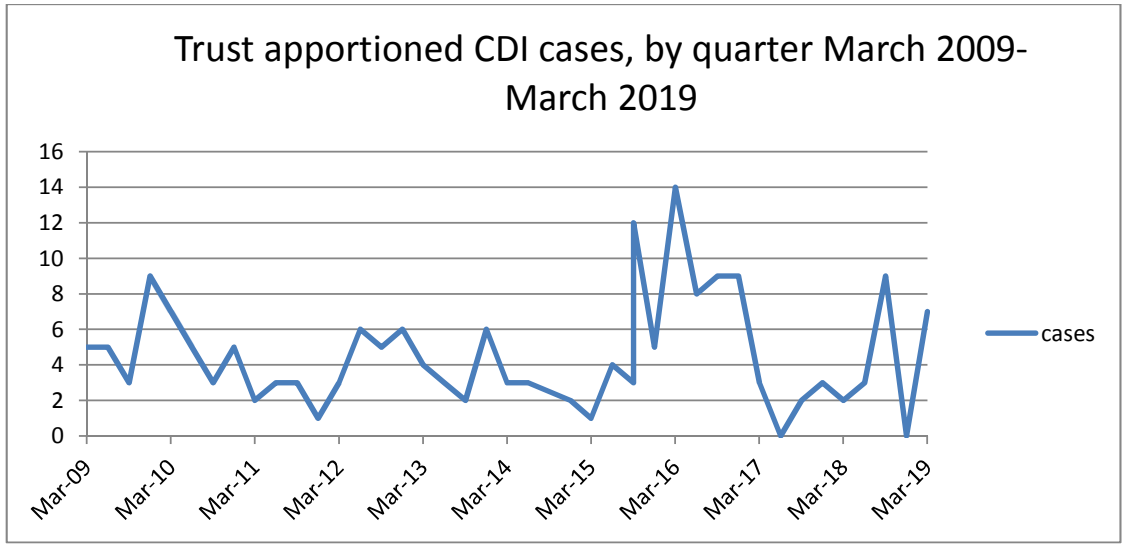
Month	*C. difficile*		MSSA BSI		MRSA BSI		*E.* coli BSI		Klebsiella BSI		*Pseudomonas aeruginosa* BSI	
	HAI	CAI*	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI
April	1	0	1	6	0	0	1	12	0	2	0	0
May	1	3	0	2	0	0	1	14	0	1	0	0
June	1	0	1	2	0	0	1	12	1	1	0	2
July	4	0	0	3	0	0	1	9	0	0	1	0
August	2	2	0	2	0	1	1	15	1	4	0	1
September	3	0	0	0	0	1	1	10	2	2	1	0
October	0	2	0	5	0	0	1	9	1	6	0	1
November	0	3	1	0	0	0	1	4	0	1	0	1
December	0	1	1	1	0	0	1	7	0	1	0	0
January	1	3	0	3	0	0	1	13	0	2	0	1
February	4**	3	1	3	0	0	2	9	0	1	0	0
March	2	4	0	4	0	0	1	16	0	2	0	2
TOTAL	**19**	**21**	**5**	**31**	**0**	**2**	**12**	**130**	**5**	**23**	**2**	**8**

C. difficile

The total number of Trust-apportioned CDI cases for 2018/2019 was 19, compared with just 7 the previous year; 29 in 2016/2017 and 35 in 2015/2016.

The annual objective of eleven or fewer cases was therefore not achieved.

Figure 1



We are currently ribotyping most, if not all *C. difficile* isolates.

The results are shown in Table 2.

Table 2 *C. difficile* ribotype results, by ward

	RIBOTYPE																
Ward where identified	**no result available**	**002**	**005**	**011**	**014**	**015**	**018**	**020**	**026**	**029**	**054**	**056**	**078**	**103**	**174**	**No growth**	**Total**
AMU		1	1					1			1				1		5
Byland																1	1
CATT	1	1												1			3
Farndale										1			1				2
Granby																	
Harlow	1																1
ITU/HDU						1			1								2
Jervaulx													2*				2
Lascelles			1														1
Littondale	3				1								1				5
MAU	1			1			1										3
Nidderdale	1							1									2
Oakdale			1														1
SROMC	1																1
Trinity			1									1					2
Grand Total	8	2	4	1	1	1	1	2	1	1	1	1	4	1	1	1	31

Ribotype 078 is quinolone resistant, and more virulent than some of the other types.

The 2 cases on Jervaulx occurred 2 months apart.

Lapses in Care

Table 3 Summary of Trust-apportioned CDI cases 2018/2019

Case No.	Gender	Age	Date of admission	Date of stool sample	Ribotype	Ward where identified	RCA conclusion
1	male	91	31/03/2018	05/04/2018	078	Jervaulx	Unavoidable, no lapses in care
2	female	76	09/04/2018	17/05/2018	054	AMU	***Inconclusive.** Didn't have enough information. genuine case ? no lapses in care
3	female	85	25/05/2018	03/06/2018	078	Jervaulx	Incidental finding. Unavoidable, no identified lapses in care
4	male	90	28/06/2018	15/07/2018	No growth	Byland	Unavoidable; incidental finding
5	female	98	12/07/2018	19/07/2018	005	AMU	**? avoidable. Possible lapse in care**
6	male	80	27/06/2018	17/07/2018	078	Farndale	Unavoidable, no contributory lapses in care
7	male	23	12/07/2018	20/07/2018	174	AMU	Unavoidable, no contributory lapses in care
8*	female	98	12/07/2018	18/08/2018	005	Trinity	Unavoidable. No lapses in care
9	male	79	20/08/2018	31/08/2018	015	ITU/HDU	RCA 11/9: unavoidable, No lapses in care
10	female	48	06/07/2018	04/09/2018	005	Lascelles	Unavoidable. No lapses
11	male	94	11/08/2018	11/09/2018	056	Byland/ Trinity	Unavoidable. No lapses in care in either location.
12	female	75	22/09/2018	26/09/2018	026	ITU/HDU	Unavoidable. No issues identified.
13	female	67	04/01/2019	08/01/2019	020	Nidderdale	Unavoidable. No lapses
14	female	89	29/01/2019	05/02/2019	-	Nidderdale	Unavoidable. No lapses
15	male	69	29/01/2019	Radiological diagnosis of Pseudomembranous colitis	-	Littondale	Unclear whether this was genuine
16	female	89	28/01/2019	11/02/2019	005	Oakdale	Unavoidable. No lapses
17	female	88	10/02/2019	13/02/2019	029	Farndale	Unavoidable. No lapses
18	male	74	28/02/2019	13/03/2019	-	Littondale	Unavoidable. No lapses
19	female	83	06/03/2019	20/03/2019	-	Granby	No lapses.

There was one possible lapse in care (Case 5). This was a 98 year old lady admitted after a fall and a long lie, who was treated appropriately on admission for a radiologically confirmed community acquired pneumonia with amoxicillin, which also covered the coliform grown in a urine sample taken on admission. A few days later, this was changed to cefuroxime by an on-call FY2 because of on-going confusion and cloudy urine. This was arguably unnecessary, but was picked up and changed the following morning by the duty consultant who stopped it. We called this a lapse in care, however it is debatable whether two doses of cefuroxime really caused her to develop CDI.

C. difficile 2019/2020 - changes to the reporting rules and new objective.
NHSI has announced that the proposed changes to the categorisation of *C. difficile* cases are going to be implemented with effect from 1 April 2019. This is to bring the UK data into line with European (ECDC) and North American (CDC) definitions.

The changes to reporting onto the Data Capture System for 2019/20 are:

- adding a prior healthcare exposure element for community onset cases
- reducing the number of days after admission to identify hospital onset healthcare associated cases from ≥3 to ≥2.

From April 2019 cases reported to the HCAI DCS will be assigned by DCS as follows:

a) **HOHA** Healthcare onset healthcare associated: cases detected in the hospital **≥2** days after admission,
b) **COHA** Community onset healthcare associated: cases that occur in the community (or ≥2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks,
c) **COIA** Community onset indeterminate association: cases that occur in the community (or ≥2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent 4 weeks,
d) **COCA** Community onset community associated: cases that occur in the community (or ≥2 days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

2019/2020 CDI objectives
The 2019/2020 CDI objective for HDFT has been set at **19** cases, based on the new categories.

PHE estimate that in most areas, 67% cases will be Trust apportioned.

At HDFT, we still encourage wards to test patients with loose stool regardless of whether they have another plausible explanation for having loose stool. Patients are tested in this hospital who might not be tested at all in some other Trusts.

Sanctions
The Commissioners are able to fine the Trust £10,000 for each case over the new objective, although this is discretionary, and it is up to the Commissioners to decide which ones, if any, will incur a financial penalty. This does not seem to have changed.

S. aureus bacteraemias (SABSI)

SABSI include both MRSA (methicillin-resistant) and MSSA (methicillin-sensitive) *S. aureus.* The numbers of both remain very low. We currently screen most admissions for MRSA, but not MSSA carriage.

There were no Trust-apportioned MRSA bacteraemias in 2018/2019, and 2 community apportioned cases.

MRSA screening

In 2014, the Government issued new guidance to NHS Trusts in England suggesting that universal MRSA screening, introduced nearly a decade previously, was discontinued in favour of screening for high-risk groups only, with no distinction drawn between elective or emergency admissions. This was based on the findings of the NOW study, commissioned in 2011 to look at the effectiveness and cost effectiveness of 6 different MRSA screening strategies, ranging from universal screening of all admissions, to no routine screening at all, with 4 options of more selected screening in between. Conceding that the effectiveness and cost-effectiveness depends on both the local prevalence rate and type of Trust, they concluded that overall, the simplest and most effective and cost-effective options were to go back to screening of high-risk groups only. These are the patients for which MRSA colonisation would cause the greatest risk of infection and poor outcome. They include all those admitted to high-risk units, without drawing a distinction between emergency and elective admissions.

The 2014 guidance was never adopted at HDFT, which currently still aims to screen all elective and emergency admissions for MRSA with a single nasal swab. In the calendar year 2018, 17,109 such MRSA screens were carried out, of which 150 (0.9%) were positive. The cost for MRSA screening that year was £80,930 based on total laboratory costs of £4.73/test but excluding nursing time; (£19,675 for laboratory consumables only at £1.15/test).

If we implemented the new guidelines, only patients in the following groups would be screened, with no distinction drawn between elective and emergency admissions.

- All admissions to Farndale and Wensleydale (regardless of speciality, ie including medical outliers)
- All trauma and orthopaedic admissions (both elective and emergency)
- All admissions to HDU/ITU
- All admissions to SCBU
- All admissions to CCU
- All admissions to the haematology/oncology side rooms on Oakdale
- Anyone with a previous history of MRSA colonisation/infection
- Anyone with a history of a hospital admission anywhere other than HDFT in the last 3 months

The total number of screens which would have been carried out under the new guidelines in 2018, based crudely on subtracting the numbers of those which would not have been done; would have been roughly 6000, a reduction of about 65%.

The cost in laboratory consumables of MRSA screening would have therefore have been ~£7000, a reduction of about £12,000.

A proposal to adopt the 2014 MRSA screening strategy will be put to the Trust later in the year.

E. coli bacteraemias

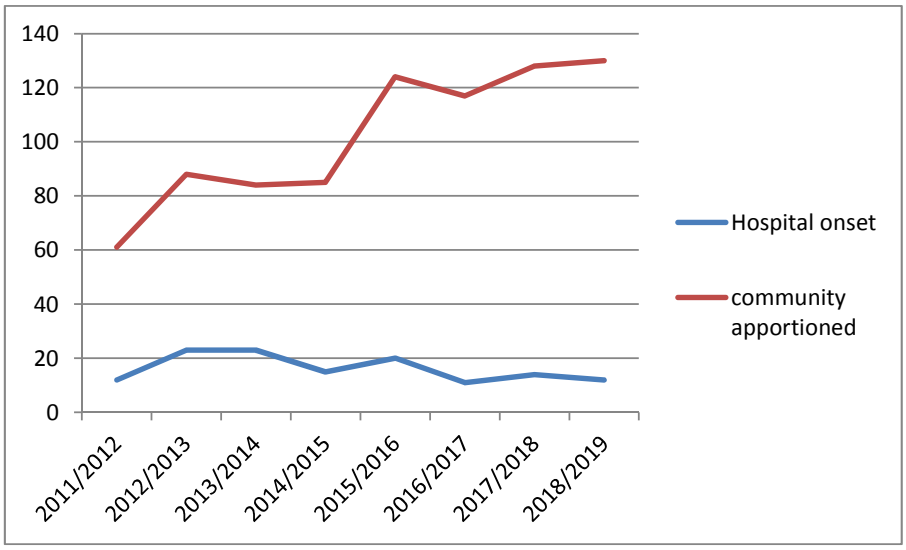


Figure 2: ***E. coli*** **bacteraemias, April 2011-March 2019, HDFT**

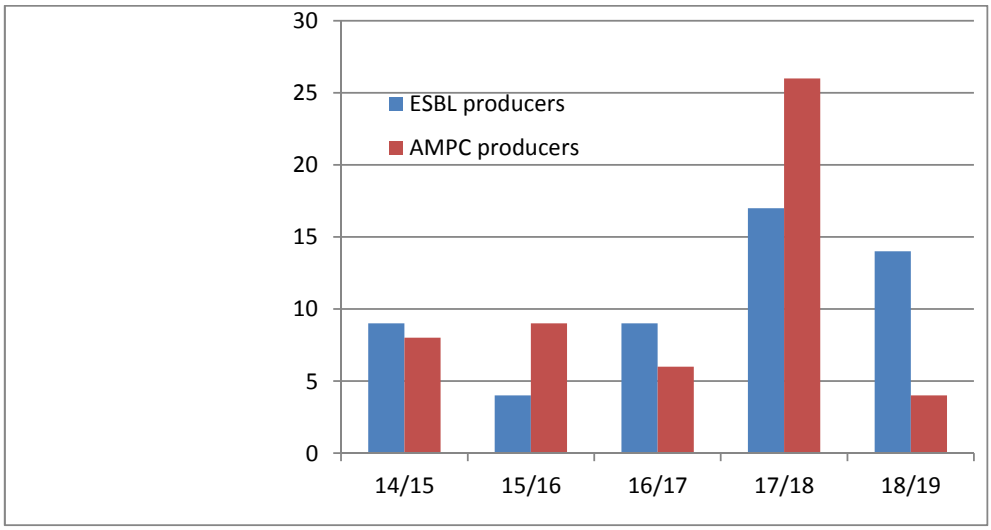
The number of community associated E. coli BSI continues to rise; the number of hospital onset cases remains the same.

Multiply-resistant organisms

Worldwide, multiply resistant organisms are becoming much more prevalent over last few years. years. While the number of carbapenems resistant organisms remains very low in the Harrogate area, the number of Gram-negative organisms producing resistance mechanisms such as AmpC beta-lactamase enzymes or extended-spectrum beta lactamases (ESBLs) has been increasing in recent years. The genes encoding for these enzymes, which destroy the beta-lactam agents including widely used penicillins and cephalosporins, are mainly found on mobile genetic elements which can be passed from strain to strain or even between species. These packages of extra-chromosomal DNA more often than not also contain genes conferring resistance to other classes of antimicrobial agents including aminoglycosides and quinolones. Treatment options can be limited.

The numbers of blood culture isolates producing Amp C and ESBL enzymes are shown in Figure 3, and in urinary isolates in Figure 4. The apparent drop in the number of Amp C producers found in blood cultures particularly over the last year is probably due to a change in reporting.

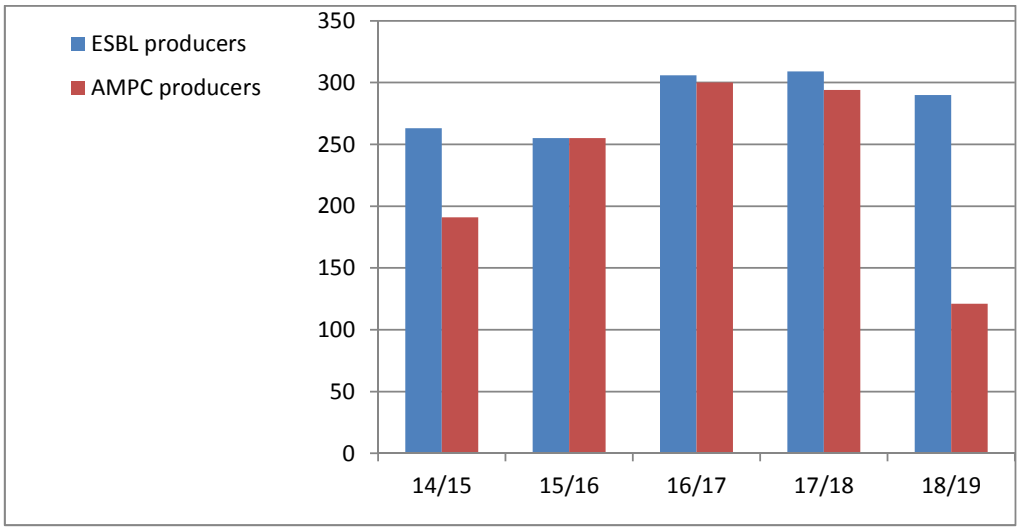
Figure 3 Amp C and ESBL producing organisms isolated from blood cultures 2018/2019



Source: LabCentre, HDFT, courtesy of Lucy Jenkinson

The number of urinary isolates producing ESBLs and Amp Cs is shown in Figure 4. Many of these will have been submitted by GPs and represent infections on the community. Because many of these will be multiply-resistant, it is not always possible to find an oral option for treatment. Patients requiring antibiotic treatment will therefore need home IVs or more probably, a hospital admission to be treated.

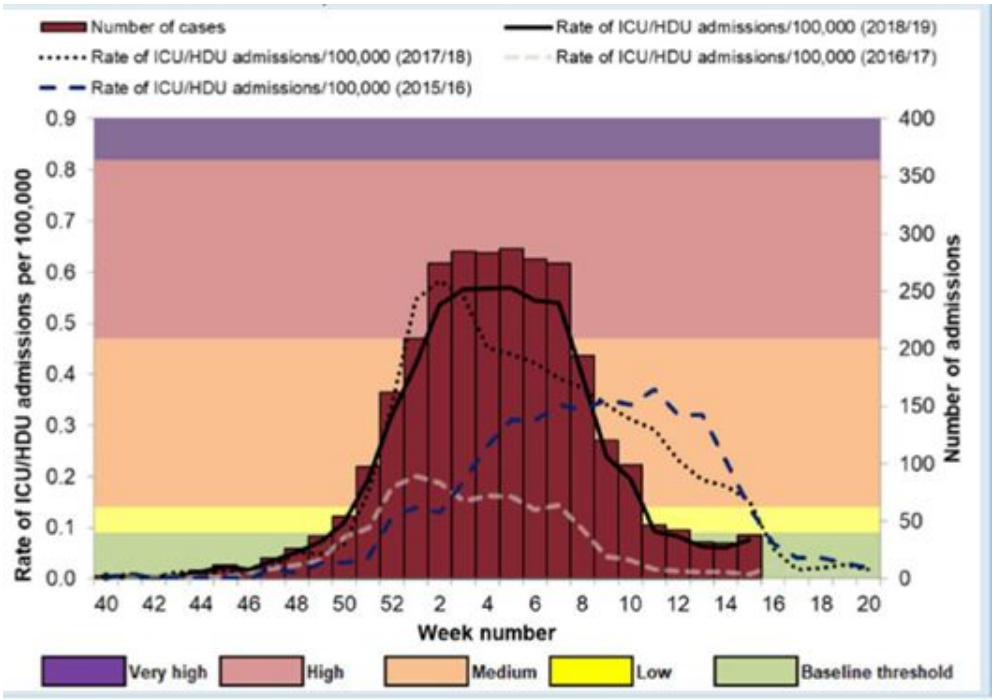
Figure 4: ESBL and AmpC producing organisms in urines



Respiratory viruses

The season kicked off properly in late December 2018, although the overall numbers were smaller than the previous year. We had 147 cases of confirmed influenza in hospitalised patients, compared with 201 the previous year. Unlike the 2017/2018 season, we did not have a single case of influenza B; there had been 72 the year before. Although there were more people admitted to ITU/HDU with a respiratory virus, there were fewer deaths, which was the same as the national picture. This was undoubtedly a reflection of there being fewer 'flu B cases in the elderly this year.

Figure 4: Weekly number of admissions of influenza confirmed admissions to ITU/HDU per 100,000 Trust catchment population, 2016/17, 2017/18, 2018/19



Source: PHE 2018/2019 winter report

All the influenza ('flu) was influenza A, either A H3, or the H1N1 2009 strain, which also caused an outbreak on Jervaulx. RSV was responsible for many admissions of elderly people with respiratory problems. The last confirmed case of 'flu was on the 19 March.

The number of hospital-acquired cases of respiratory virus (diagnosed 5 days or later into the hospital admission) was reduced compared with the previous year. There were 23 cases of hospital-acquired 'flu, compared with 36 the previous year.

Of 343 patients with confirmed respiratory viruses, 276 (80.5%) were community acquired (CAI) 55 were hospital acquired. Table 4 shows the number of the 3 principal viruses : influenza, RSV and parainfluenza (corona virus, rhinovirus/enterovirus and several others not shown).

Table 4 Influenza, RSV and parainfluenza viruses amongst hospitalised patients, 2018/2019.

Location when spec taken	Influenza			RSV			Parainfluenza		
	CAI	HAI	Indeterminate	CAI	HAI	Indeterminate	CAI	HAI	Indeterminate
AMU/MSS	13			2	1				
Byland	1	1	1		1				
CATT/MAU	47	1		19		1	1		
CAT clinic	11						1	1	
ED	17								
Farndale	2				1		1		
Granby	2	4	2			1			
Harlow				1					
ITU	5			2			1		
Jervaulx		11*			7				
Lascelles		1							
Littondale	1	2							
Nidderdale	1	1							
Maternity AC	1								
Oakdale	3	1			2	1	1		
Pannal	1	1							
SROMC	2			7					
Woodlands	7			3			2		
Rowan	3								
OPD	4								
Histology	1								
Total cases:	121	23	3	34	12	3	7	1	0
Virus count:	147			49			8		

CAI - case confirmed within 48 of admission
HAI - case confirmed on day 5 of admission, or later
Indeterminate - case confirmed on day 3 or 4 of admission
NB there are currently no accepted standard definitions for these terms

RSV was predominately a disease of the elderly this year, with very few paediatric cases compared to previous years.

Deaths from hospital-acquired viruses

Of the 55 hospital acquired cases of respiratory viruses, 11 died within 30 days of their diagnosis (all causes). Just 2 of these had 'flu; both were very frail elderly patients who were part of the Jervaulx outbreak. One of them had influenza listed under part 1a of the death certificate.

(2 patients had RSV, 4 had coronavirus, 2 had rhinovirus/enterovirus).

In 2017/2018, ten patients with hospital acquired 'flu died within 30 days; eight had influenza listed as a cause of death on the death certificate.

Jervaulx outbreak, 10-21 January 2019

In January, there was an outbreak of respiratory viruses on Jervaulx; 4 separate viruses were circulating. 10 patients were diagnosed with influenza A (HIN1, 2009); 5 with RSV; one had both. Another 4 patients acquired coronavirus. 9 of the flu cases were diagnosed in the first 4 days, and were mainly confirmed to 2 adjacent bays (bays 4 and 5) with a very high hit rate. All patients with confirmed 'flu were treated with oseltamivir, and the others put on prophylaxis. About half had been vaccinated.

There was also an unusually high number of staff affected; by the 16 January, 18 staff members were off sick from the ward. 13 had been vaccinated against 'flu. We tested as many as we could either before they left after becoming unwell or on return to work. 6 had laboratory confirmation of a respiratory virus - 5 with 'flu A H1N1 2009, one with RSV and one with both.

The staff samples were sent to the National Virus Reference Laboratory at Colindale for inclusion within the national whole genome sequencing scheme. Sequencing of the haemagglutinin (HA) gene showed that the virus in these samples belonged to HA genetic group 6B.1, which is the predominant genetic group detected among the influenza (H1N1)pdm09 viruses circulating during the influenza season 2018/19. ...and was genetically similar to the A(H1N1)pdm09 strain included in the 2018/19 influenza vaccine".

Put simply, this confirmed that there was one strain circulating- ie this *was* an outbreak, but also that this particular virus was covered by the vaccine that season. The high number of people, both staff and patients, affected within such a tight window was suggestive of a point source, although it will never be possible to establish who the source might have been, and doing so would not have been particularly helpful.

The affected patients were quickly isolated or cohorted, and we managed to re-open the ward completely within 11 days, which was no mean feat. Having access to in-house same day testing is likely to have been the main factor in enabling this to happen.

Antimicrobial Stewardship Report for IPC Annual Report 2018-19

Dr Katharine Scott, Consultant Microbiologist

Antimicrobial guidelines

New antimicrobial guidelines were produced:

1. Guideline for the investigation and management of recurrent urinary tract infections in non-pregnant adult women: antimicrobial prophylaxis
2. Antibiotic treatment of gastrointestinal infections in children
3. Antibiotic treatment of skin and soft tissue infections in children

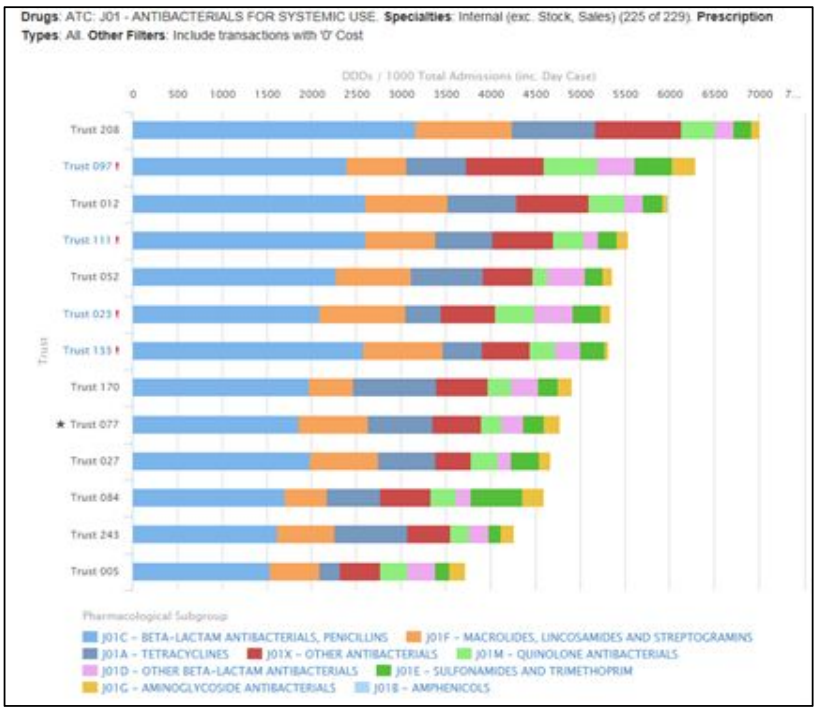
Revisions were made to existing guidelines:

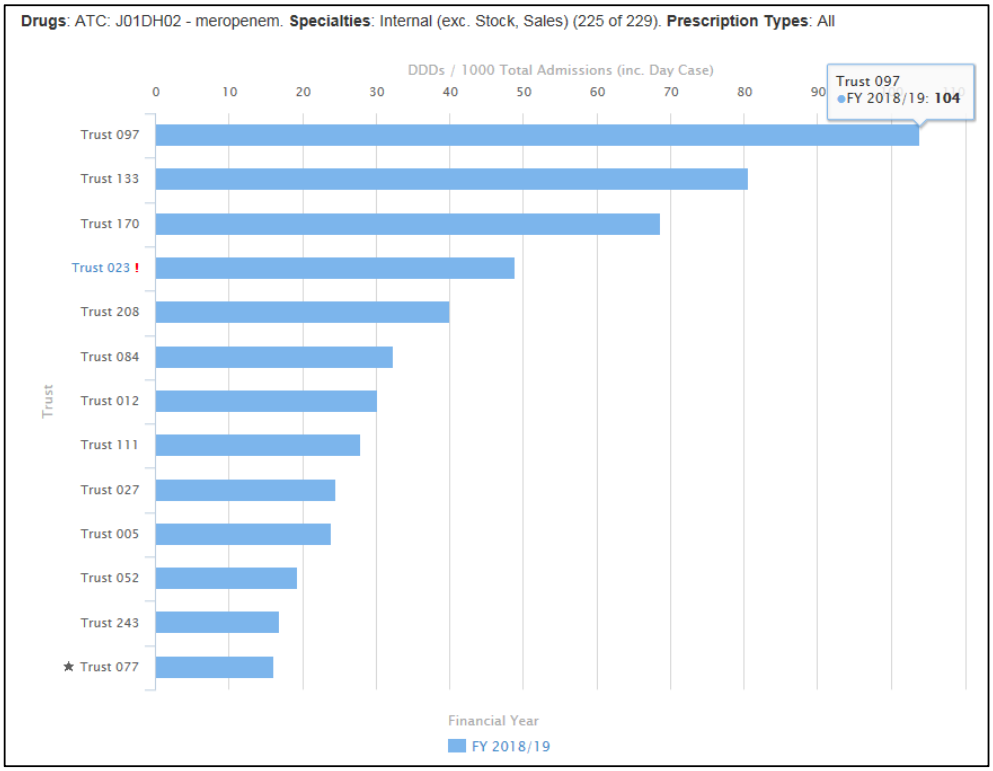
1. Replacement of recommendations for levofloxacin with alternatives where possible
2. Shortened antibiotic course lengths on basis of new evidence and/or new NICE guidelines

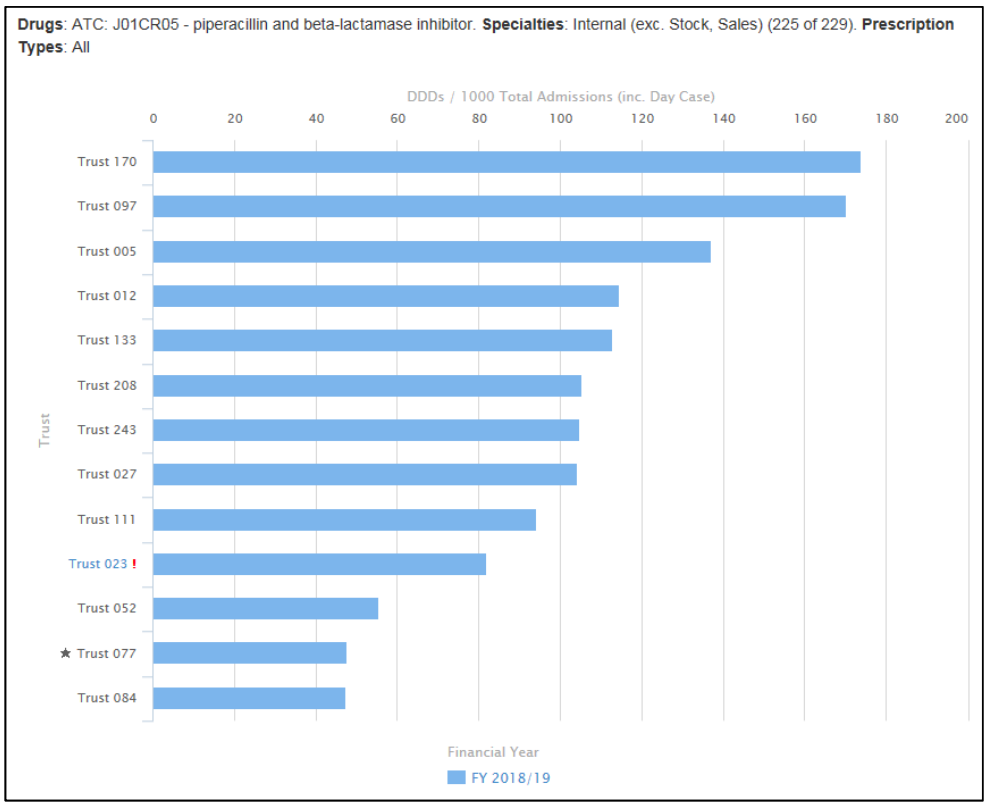
Following an investigation into a patient who developed vestibulitis and nephrotoxicity following a prolonged course of gentamicin, a patient-information leaflet was developed warning of potential adverse effects.

Antimicrobial Usage

HDFT continues to compare favourably to other Trusts in the region in terms of antibiotic use, particularly with regards to low use of broad spectrum agents (e.g. meropenem and piperacillin/tazobactam). Harrogate is Trust 077 (asterixed) on the following charts.



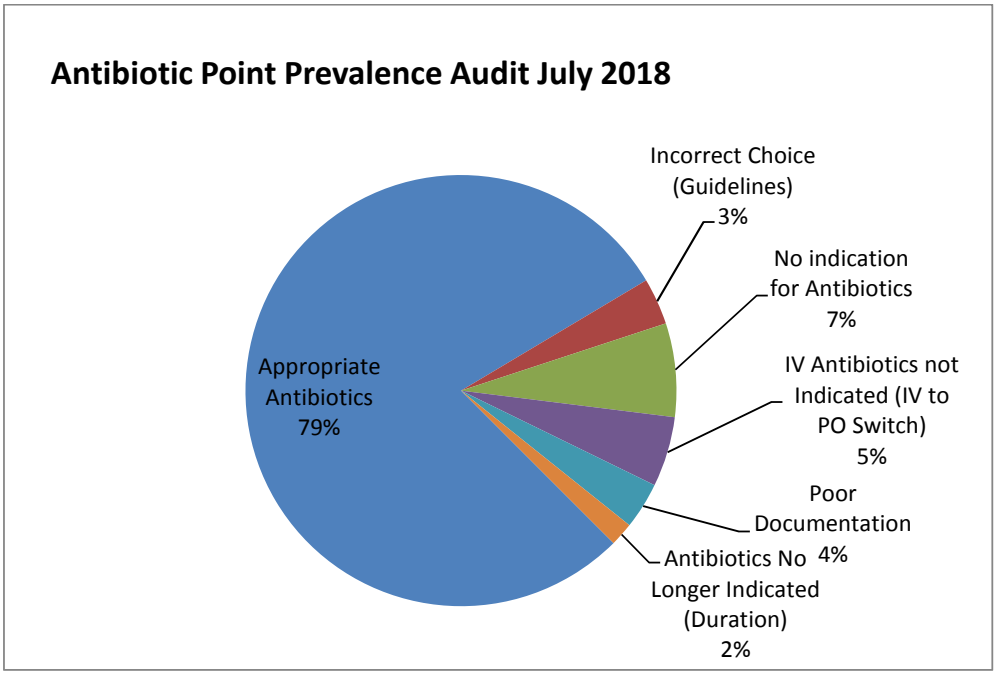

Drugs: ATC: J01DH02 - meropenem. Specialties: Internal (exc. Stock, Sales) (225 of 229). Prescription Types: All
DDDs / 1000 Total Admissions (inc. Day Case)
0
10
20
30
40
50
60
70
80
90
Trust 097
FY 2018/19: 104
Trust 097
Trust 133
Trust 170
Trust 023 !
Trust 208
Trust 084
Trust 012
Trust 111
Trust 027
Trust 005
Trust 052
Trust 243
★ Trust 077
Trust
Financial Year
FY 2018/19

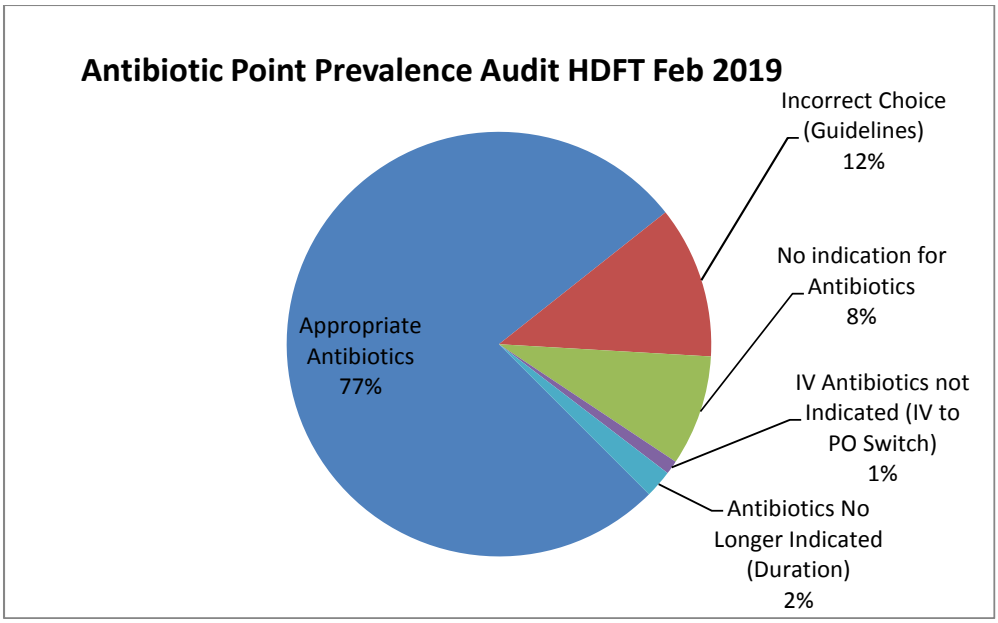

Drugs: ATC: J01CR05 - piperacillin and beta-lactamase inhibitor. Specialties: Internal (exc. Stock, Sales) (225 of 229). Prescription Types: All
DDDs / 1000 Total Admissions (inc. Day Case)
0
20
40
60
80
100
120
140
160
180
200
Trust 170
Trust 097
Trust 005
Trust 012
Trust 133
Trust 208
Trust 243
Trust 027
Trust 111
Trust 023 !
Trust 052
★ Trust 077
Trust 084
Trust
Financial Year
FY 2018/19

14

Audit

The Antimicrobial Stewardship Team continued to conduct 6 monthly antibiotic point prevalence audit; all inpatients prescribed antibiotics on a given day in July and February were reviewed. The results demonstrate appropriate prescribing in almost 80% of cases. A business case has been put forward for the acquisition of the MicroGuide antibiotic prescribing app which it is hoped will improve access to the Trust guidelines.





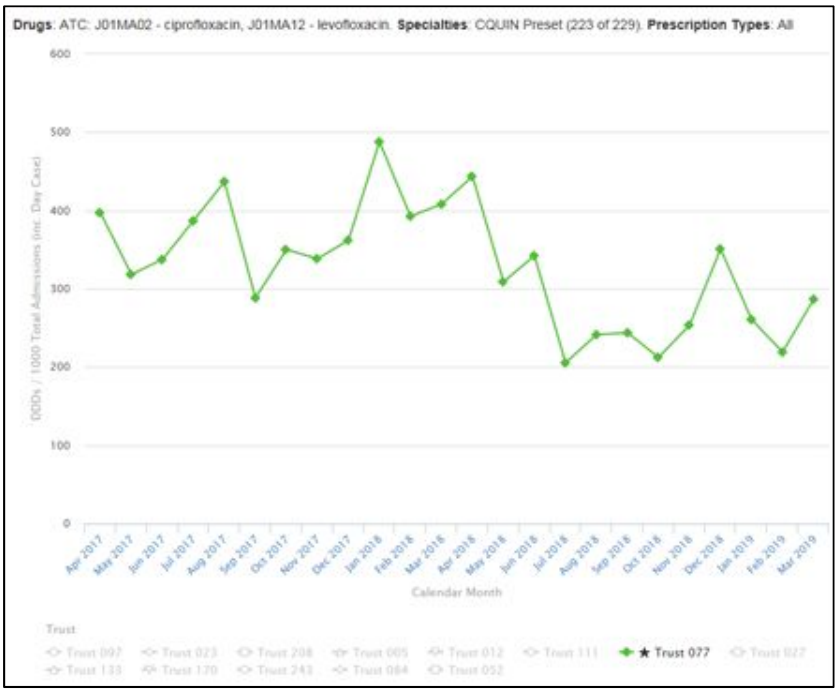
14

MHRA Alert Regarding Fluoroquinolone Use

This alert was published on 21 March 2019 warning that 'disabling, long-lasting or potentially irreversible adverse reactions affecting musculoskeletal and nervous systems have been reported very rarely with fluoroquinolone antibiotics. Fluoroquinolone treatment should be discontinued at the first signs of a serious adverse reaction, including tendon pain or inflammation.'

We are aware of two cases of tendinopathies from patients treated with levofloxacin at HDFT prior to this alert. In view of this we had already made changes to our antibiotic guidelines in August 2018, reducing the number of recommendations for levofloxacin in particular.

The following chart shows how our use of fluoroquinolones (levofloxacin and ciprofloxacin) has fallen in the preceding two years:



At the time of writing, a hyperlink to the MHRA alert has also been incorporated into the Trust antibiotic guidelines where fluoroquinolones are recommended. A patient information leaflet is also available.

CQUIN

The Trust did not participate in CQUIN reporting relating to antimicrobial stewardship in this period.

Decontamination Committee Report
Dr Richard Hobson

Objectives for 2018/19

1) To fulfil all best practice requirements with the recently released Health Technical Memorandum 01-01(A-E): Management and decontamination of surgical instruments (medical devices) used in acute care (carried forward from 2017/18).
2) To ensure compliance to ISO16442:2015 – Controlled environment storage cabinet for processed thermolabile endoscopes (carried forward from 2017/18).
3) To comply with the recommendations of HTM 01-06 (Decontamination of flexible endoscopes) in reference to residual protein testing procedure. A system is to be trialled and implemented for the use in endoscope washer disinfectors comparable with existing system used in the instrument washer disinfectors.
4) Tracking and Traceability. Ensure that the Trust puts in place a process or processes to improve the tracking and traceability of surgical items sent for reprocessing.

1. **To fulfil all best practice requirements with the recently released Health Technical Memorandum 01-01(A-E): Management and decontamination of surgical instruments (medical devices) used in acute care (carried forward from 2017/18).**
   'Best practice' includes regular protein challenge testing with devices that simulate the attachment of prion protein to instruments and whose analysis is quantitative. We have been advised by the AE(D) that the technology needed to achieve quantitative results is not yet commercially available. The AE(D) has advised us that we fulfil best practice requirements with the above (unachievable) exception, which is not achievable.

2. **To ensure compliance to ISO16442:2015 – Controlled environment storage cabinet for processed thermolabile endoscopes (carried forward from 2017/18).**
   This objective is complete. The relevant reports are compliant with ISO16442:2015.

3. **To comply with the recommendations of HTM 01-06 (Decontamination of flexible endoscopes) in reference to residual protein testing procedure. A system is to be trialled and implemented for the use in endoscope washer disinfectors comparable with existing system used in the instrument washer disinfectors.**
   This objective suffers from exactly the same limitation as objective 1, and is similarly not achievable given the current status of process challenge testing technology..

4. **Tracking and Traceability. Ensure that the Trust puts in place a process or processes to improve the tracking and traceability of surgical items sent for reprocessing.**
   Processes are being implemented to improve tracking and traceability. Most recently, Clare Cressey has worked with the Clinical Skills Trainers to develop a video that shows the tracking and traceability procedures, which it is anticipated will be incorporated into the training of the community teams for whom this is most relevant, namely podiatry and community dental. It should be noted that the Trust is moving towards a GS1 standard, and eventually all Medical Devices used on patients will be barcoded and scanned. It is anticipated that this process will make failure of instrument tracking and traceability almost impossible, if not impossible.

   This objective is carried over to 2019/20 as it is not yet complete due to lack of resources.

Objectives for 2019/20

1. Tracking and Traceability. Ensure that the Trust puts in place a process or processes to improve the tracking and traceability of surgical items sent for reprocessing (carried over from 2018/19).
2. Ensure that the trust's procedures for decontamination of intracavitary devices (transoesophageal probes etc) is consistent with the relevant guidance (mainly, Guidance for the decontamination of intracavitary medical devices: the report of a working group of the Healthcare Infection Society, Bradley CR, Hoffman PN et al (2018), *Journal of Hospital Infection*; 101: 1-10).
3. Improve attendance at the decontamination committee meetings.

Decontamination Report Appendix 1: Attendance monitoring

Appendix 1: Attendance monitoring

Membership	Meetings				Total	%
	25 April 2018	8 August 2018	19 October 2018	19 January 2019		
Consultant Microbiologist	✓	✓	✓	✓	4	100
Manager of Sterile Services, HHFM	✓	✓	✓	✓	4	100
AP (D), Estates Manager Compliance & Safety, HHFM	✓	✓	✓	✓	4	100
HIPCN		✓	✓	✓	3	75
CIPCN				✓	2	50
Deputy Manager Decontamination Services, HHFM						
Managing Director, HHFM		✓			1	25
Manager, Endoscopy	✓	✓			2	50
CIA representative						
Sister, Outpatients						
Day Surgery Representative	✓		✓		2	50
Main Theatres Representative						
AE (D)			✓	✓	2	50
Medical Device Safety Officer						
Quality Production Services Manager	✓	✓	✓	✓	4	100
Quoracy: Total members per meeting Quorum (8)	6	7	7	7		
In attendance – General Manager, SSD & Equipment Library (to be added to TOR at next review)			✓	✓	2	50

Infection Prevention and Control and TB Service Annual Work Plan April 2019 – March 2020

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/20
1	Maximise collaborative working opportunities to impact infection prevention and control practices across HDFT hospital and also North Yorkshire community settings	Evidence of integrated working systems across the whole health economy	Quarterly Quality of Care Team meetings	SA	SA	Mar-20	
			Evaluate effectiveness of HIPC AND CIPC service through MRSA and CDI patient user surveys	AG / SO	SA	Mar-20	
			Evaluate revised IPCN weekend On-Call Service	AG / JC	SA	Jan-20	
			Continually review and revise IPC working systems and staffing establishment to ensure effective use of resources and achieve cost improvement target	AG / SA	SA	Mar-20	
			Work collaboratively with the CCG and key stakeholders to deliver the Gram-negative Bacteraemia Plan	AG / SA / SO	SA	Mar-20	
2	Revise Trust IPC Policies	Publication of updated policies	Review content and format of policies due to be updated. Produce 'Guidance on a page' to accompany policies	SA / AG	SA	Mar-20	
			Review section 003 Procedures for individual diseases (A-Z)	AG	SA	Nov -19	
			Review section 007 Haemophilus influenzae	JC	SA	June-19	
			Review section 008 Chickenpox and Shingles	JC	SA	June-19	
			Review section 009 *Clostridium difficile*	AG	SA	Nov-19	
			Review section 010 Respiratory Virus	JC	SA	Nov -18	
			Review section 011 Scabies	SA	SA	Jan -20	
			Review section 014 Standard Precautions	AG	SA	Mar-20	
			Review section 020 Decontamination policy items A-Z	RH	SA	Mar-20	
			Review section 021 Bed Management movement of patients	AG	SA	Nov-19	
			Review 031 Principles of asepsis	IG	SA	Oct-19	
			Review section 027 Hospital outbreak	JC	JC	Jul-19	
			Review section 026 Animals and pets in hospital	IG	SA	Jun-19	

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/20
			Review section 042 Root cause analysis	JC	JC	Jul-19	
3	Revise Policies for Domiciliary Care	Policies available on the website	Review and amend policies for Domiciliary Care and make available on the CIPC website	GJ	SA	Mar-20	
4	Deliver education to reduce HCAI		Deliver the Preventing Infection (PIC) two day course held three times a year for Community H/SC Staff	SO	SO	Mar-20	
			Deliver IPC Masterclass for Registered Nurses in the Trust	AG	SA	Mar-20	
			Deliver an IPC Masterclass for band 2 and 3 staff	AG	SA	Mar-20	
			Develop new outbreak resources, e.g. posters to support HCAI knowledge, skills and practice	AG / CK	SA	Nov–20	
			Deliver campaign to prevent the spread of Norovirus in hospital and community	AG / GM / SO	AG	Nov -20	
			Deliver targeted education campaigns e.g. Prevent dehydration and UTIs	AG / SO	SA	Mar-20	
			Participate in Global Hand Hygiene Awareness initiatives and Antimicrobial Stewardship campaign	AG / SO	SA	Nov 20	
			Deliver targeted training sessions to underachieving hospital wards /departments, GP Practices, Care Homes, Dom Care establishments	AG / SO	SA	Mar-20	
5	Audit practices to ensure policies are adhered to		Isolation – Door closed	GM	AG	Dec-19	
			Isolation – Audit of Equipment	WH	AG	Mar-20	
			Cleanliness of patient fans – wards only	WH	AG	Mar-20	
			BBV – Audit of sharps disposal	AG	SA	Mar-20	
			CDI – Monthly audit of commodes and raised toilet seats	WH	AG	Mar-20	
			MRSA – Audit of patient information received	GM	AG	Mar-20	
			Correct use of water filters	WH	AG	Mar-20	
			HH – Audit of posters and point-of-care hand foam	WH	AG	Mar-20	
			HH – Quarterly 'Secret Shopper' Audit of patient hand hygiene	GM	AG	Mar-20	
			IV – *Saving Lives* audit for insertion / on-going care	Ward/ Dept	AG	Mar-20	
			CVC – *Saving Lives* audit for insertion / on-going care	Ward/	AG	Mar-20	

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/20
				Dept			
			Decontamination – Audit of disinfectant availability	WH	AG	Mar-20	
			Decontamination – Blood glucose testing equipment how often	WH	AG	Mar-20	
			SSI – *Saving* Lives audit	AG	AG	Mar-20	
			No dip project for care homes in York and SR localities	SO / CG	SO / SA	Mar 20	
			Monthly IPQAT audits (HH/Deco/SP)	AG	AG	Mar-20	
			HH / Deco Monthly Saving Lives audits for departments	AG	AG	Mar-20	
			IV- Monthly cannula audits	CK / AG	AG	Mar-20	
			Annual hand hygiene assessments for lone working community staff (Podiatrists, Dental, Community Nurses, GP OOHs, Imm and Vac)	SO	SA	Mar-20	
			Annual IPC environmental audits of Ripon and Selby MIU Units, GP OOH Service, Podiatry, Ripon Hospital including Trinity Ward, Outpatients, Physiotherapy, Maternity, Radiology	SO	SA	Mar-20	
			Submission of mandatory reports to Public Health England via DCS – MRSA / MSSA bacteraemia; *Clostridium difficile* infection; glycopeptide-resistant enterococcal bacteraemia; bacteraemia Gram-negative	CR / AG	JC	Mar-20	
			Enable and support T/O department in conjunction with P/SC directorate to review and implement orthopaedic surgical site infection surveillance in addition to mandatory modules. (Hemiarthroplasty July-September 2018)	IG / AG	JC	Mar-20	
			QIST surveillance programme	IG / AG	JC	Mar-20	
6	Monitor HCAI through implementation of surveillance programme	Achievement of DH objectives for MRSA Bacteraemia (0) and Clostridium difficile infection (12); Reports of year-on-year reduction of hospital attributed HCAI	Continue Alert Organism/Condition surveillance (Hospital-acquired MRSA; *Clostridium difficile* infection and colonisation; MRGNB; norovirus; MSSA in SCBU; Pseudomonas in ITU, SCBU / Haematology Ward; CPE; Urinary catheter prevalence	AG / CR	AG	Mar-20	
			Seek patient feedback /experience from patients with *Clostridium difficile* (community)	SO / SC	SA	Mar-20	
			Seek patient feedback / experience with MRSA screening information (hospital)	AG / GM	SA	Mar-20	
			Review IPC resources on Trust Intranet, HDFT website and NYIPC website	CR / AP	SA / AG	Mar-20	

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/20
7	Further improve communication about HCAI with patients and carers	Increased engagement about HCAI with patients and carers	Implement Ward Hygienist action plan and continually review service	AG	SA	Mar-20	
			Support implementation of Ward Hygienists audits	AG	AG	Mar-20	
			Drop in workshops for decontamination of commodes	WH / AG	AG	Aug-19	
8	Improve cleanliness of equipment and the environment within inpatient settings	Reduction in HDFT-acquired CDI cases	Support PIR process for all NY community cases of MRSA bacteraemia	SO	SA	Mar-20	
			Contribute to CCG RCA review meetings for CDI cases	SO	SA	Mar-20	
			Provide monthly CDI reports and quarterly HCAI assurance reports to the CCG	SO	SA	Mar-20	
9	Contribute to reduction of HCAI across community settings	Achievement of DH objectives for *Clostridium difficile* infection for the NY CCGs	IPC Audit programme for HDFT community bases, annual environmental audit for: • MIU's at Selby and Ripon • Podiatry across North Yorkshire • Dental across North Yorkshire • Ripon Hospital – Trinity, OPD, Physiotherapy, Radiology, Maternity	SO	SA	Mar-20	
			• Provide a reactive service to care homes as per Service Description • Use surveillance to identify and prioritise care homes requiring additional support • Provide IPC education and support for homes requiring additional support • Produce regular educational newsletters • Provide up to date IPC resources on the website	SO	SA	Mar-20	
			Transfer resources onto updated website	AP	SO / SA	Aug-19	
10	Evidence of compliance with IPC Policies	Implementation of an audit programme and audit of HDFT Community Services	Raising awareness of IPC resources to purchase and download. Email newsletters to care homes and GP Practice bi –monthly	AP	SO / SA	Mar- 20	

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/20
11	Prevention of HCAI in NY Care Homes	Provide IPC Resources	• Active marketing of IPC resources • Regular communication messages and use of social media	AP	SO / SA	Mar-20	
12	Continued development of Community IPC website. Maximise Marketing of resources	Increased number of hits to the website and achievement of cost improvement target (£73.5K)	Achieve income generation target of £73.5K	AP / SO	SO / SA	Mar-20	
			Work collaboratively with the CCGs to prevent UTIs and reduce the number of cases of E.coli bacteraemia in line with the national target and Gram-negative Bacteraemia Action Plan	SO	SO / SA	Mar-20	
			Develop working SOPs for periods of reduced staffing	KC	SA	Aug-19	
13	Reduction of Gram-negative bacteraemia cases in the community	Achievement of reduction target	• Produce regular newsletters for healthcare professionals raising the awareness of TB • On-going Quarterly reports and Annual report for the CCGs and LA • Grand ward rounds at YDH and SGH	KC /SN KC KC	SA SA KC	Mar-20 Mar-20 Mar-20	
14	Develop SOPs for dealing with periods of reduced capacity	SOPs developed	• Produce Quarterly reports utilising figures from Systmone • Produce Annual Report and attend LA Assurance Meeting to discuss	KC KC	KC / SA KC / SA	Mar-20 Mar-20	
15	Nurses unable to prescribe	Nurse prescribing course completed	• Enrol on course	AM, KC	SA	Mar-20	
16	Raise awareness of TB	Reduce incidence of TB	• Regular Newsletters to be produced	SN /KC	KC	Mar-20	
17	Provide assurance to the CCGs and LA	Quarterly and Annual Reports provided	• Quarterly and Annual Report to be produced and discussed with the CCGs / CCs	SN/KC	SA	Mar-20	

Harrogate and District NHS Foundation Trust

Date of Meeting:	**27 November 2019**	**Agenda item:**	**5.6**
Report to:	**Trust Board of Directors**		
Title:	Report by the Director of Workforce and Organisational Development		
Sponsoring Director:	Mrs Angela Wilkinson, Director of Workforce and Organisational Development		
Author(s):	Mrs Angela Wilkinson, Director of Workforce and Organisational Development		
Report Purpose:	**Decision** ☐ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	• **Recruitment of Non-Executive Directors Update** • **Recruitment of Company Secretary Update** • **First Line Leader Pilot Programme Evaluation**		

Related Trust Objectives

To deliver high quality care	✓	**To work with partners to deliver integrated care:**	✓	**To ensure clinical and financial sustainability:**	✓

Key implications	
Risk Assessment:	Any identified risks are included in the Directorate and Corporate Risk Registers and the Board Assurance Framework.
Legal / regulatory:	
Resource:	None identified
Impact Assessment:	Not applicable
Conflicts of Interest:	None identified.
Reference documents:	None appropriate
Assurance:	Not applicable.

Action Required by the Board of Directors:

The Board of Directors is requested to:

- **Note** the content of the report and comment as required

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Harrogate and District NHS Foundation Trust

1. Sickness Absence

The Trust sickness absence rate in October was 5.38% which is an increase from September's rate of 4.44%. This remains above the Trust target of 3.9%. HR Business partners are working in partnership with their directorate management teams to ensure they are sighted on the causes and the main areas of absence. Local sickness absence recovery/management plans are in place to assist with improvement. The HR review of the Managing Attendance policy is underway with our stakeholder groups. Our approach to Health & Wellbeing is also being reviewed, to develop additional ways of supporting our colleagues to stay well, both physically and mentally.

2. Retention

Turnover for October shows a slight decrease to 12.68% from 12.77% in September. This has remained fairly static and the recruitment and retention group continue to meet on a monthly basis to discuss a number of initiatives.

3. Appraisal Rate

There has been an increase in appraisal rates to 72.64% in October from 68.98% in September. We are currently reviewing appraisal arrangements by asking Clinical Directorate Boards for their views on current arrangements to seek ways we can enhance these.

4. Recruitment of Non-Executive Directors

Two Non-Executive Directors of the Trust indicated that they would not be seeking a third term when their second terms expire on 31 December 2019 and 29 February 2020.

In recruiting for their replacements it was agreed that one of the appointed candidates would have significant financial expertise, whilst the other should have experience of digital and/or organisational transformation.

The recruitment process commenced on 22 July 2019 and the advertisement closed to applicants on 27 August 2019. Thirteen candidates were initially long-listed and five candidates were shortlisted at a meeting of the Remuneration, Nominations and Conduct Committee (RNCC) on 30 September 2019.

Final interviews took place on 14 October 2019. The interview panel was comprised of the members of the RNCC and an independent member – the Chair of another Foundation Trust. In addition a Focus Group, chaired by a Non-Executive Director and including Governors, Non-Executive and Executive Directors, assessed each candidate and made suggestions to the interview panel about areas which should be probed specifically.

The interview panel agreed that three candidates were very strong and following considerable discussion it was concluded that they would, individually and collectively, bring an excellent range of diversity of relevant experience.

It was therefore agreed that in order to retain all three preferred candidates it would be appropriate to create a seventh Non-Executive Director position which would remain in place until the next Non-Executive Director vacancy on the Board of Directors, which is

likely to be 31 October 2020. This would therefore avoid a costly and time-consuming recruitment process at that time.

A proposal to create a seventh position was approved by the Board of Directors at a meeting on 30 October 2019.

5. Recruitment of Company Secretary Update

Interviews were held during early November, and a successful candidate was identified through this process. A conditional job offer has been made, and the candidate is currently undertaking a 'fit and proper persons' test. Their start date is yet to be confirmed.

6. First Line Leader Pilot Programme Evaluation

The two pilot programmes of the First Line Leader Programme, which covered 40 delegates, concluded during October, and the initial evaluation of these has been very positive. The word cloud shown below highlights some of the feedback. The table below shows self-assessment of improvement in leadership skills (median shift in performance across all 40 delegates on a scale of 1 to 10):

1. My commitment to taking positive steps to maintain my own wellbeing. +3
2. My confidence as a Leader in creating a vision for my team. +3
3. My confidence as a Leader in being kind, compassionate and inclusive. +3
4. My confidence as a Leader to challenge poor performance/behaviours. + 2.5
5. My confidence as a Leader to deal with a conflict situation. + 2

As a result of the positive feedback and anecdotal shifts in behaviour that have been reported, the programme is being roll-out from November and throughout 2020, with the aim of every first line leader attending. The programme is also being embedded into Induction arrangements for new starters who are joining the Trust in leadership positions.

Staff Survey

An active campaign is underway to achieve the best possible uptake of the staff survey which runs for 8 weeks until 29 November. The HR team have been out and about across the hospital site with laptops and stands encouraging people to talk about the survey and complete it, as well as ordering paper copies for nursing and care support worker staff. Paper copies were delivered to all areas w/c 11 November to see if that encourages easier access to the survey for busy clinical staff.

Harrogate and District NHS Foundation Trust

Flu

The national target for uptake of flu vaccination has been set at 80% and at the time of writing, the number of vaccinated staff is 52% overall (52.7% clinical and 53.14% non-clinical). Using a multi-disciplinary team approach, a planned and managed programme is underway to ensure the best uptake in the interests of patients and staff alike. Vaccines are being delivered in batches and distributed in a coordinated way across community settings and peer vaccinators to ensure high risk areas and clinical staff are the main focus.

A Wilkinson
Director of Workforce and Organisational Development
November 2019

Harrogate and District NHS
NHS Foundation Trust

Board Committee report to the Board of Directors

Committee Name:	Quality Committee (QC)
Committee Chair:	Laura Robson NED
Date of last meeting:	6 November 2019
Date of Board meeting for which this report is prepared	27 November 2019

Summary of live issues and matters to be raised at Board meeting:

Hot Spots:
The committee discussed at length the current A&E performance and the actions in place to manage increasing demand. The committee was assured that patients who were in greatest clinical need were seen immediately. There were no reported clinical incidents and patient safety remained priority. Patient experience and staff wellbeing were the main concerns.
The complaints flow chart developed following the RPIW was received along with an update on progress with the action plan. A small improvement in response times has been noted.

Board Request for QC to seek assurance:
No new requests.

Reports Received:
Quality improvement project.
There was no presentation this month.

Quarterly Directorate Governance report
The governance report from Planned and Surgical care was received. The report detailed a range of information regarding patient feedback, incidents, pressure sores, falls. Also a wide range of awards and good practice was detailed within the report.

Reports received.
Influenza Vaccination – A verbal up date was received. Take up was at 39% the morning of the meeting.
7 Day service- Report received detailing progress delivering 7 day services. An audit against standards had been undertaken. The trust is non-compliant against two standards. Standard 2 - time to first consultant review and Standard 8 -Daily Review. The report detailed actions in place and progress that has been made since the last audit. Data interpretation for this audit is difficult.

Safety Visits Safety visits have been undertaken in Maternity and SCBU. The visits had been positive with staff very proud of the service they deliver. Maternity had a number of pieces of equipment that required replacement; including delivery beds. A source of funding has since been identified. SCBU staff were concerned about the reduction in activity and numbers of babies requiring special care.

Quality Priorities
Increasing patient and public participation in the development of service
This report should have been received in October and was not available. Directorates are required to provide information on their progress against this improvement priority.

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

A&E standard performance.

Matters for decision

None

Action Required by Board of Directors:
The board is requested to approve the reviewed terms of reference for the committee

Harrogate and District NHS
NHS Foundation Trust

Board Committee report to the Board of Directors

Committee Name:	Quality Committee (QC)
Committee Chair:	Laura Robson NED
Date of last meeting:	2 October 2019
Date of Board meeting for which this report is prepared	27 November 2019

Summary of live issues and matters to be raised at Board meeting:

Hot Spots:
The Committee receive a detail explanation of the outcomes from the RPIW into the management of complaints. The process had been very productive and plans for improvement were now being worked through in detail. The committee will continue to monitor improvement in complaints response times and implementation of the action plan.

Board Request for QC to seek assurance:
No new requests. The board is now seeking a resolution to ReSPECT directly.

Reports Received:
Quality improvement project.
The infection control team attended the meeting to explain their team silver award. They were extremely engaging and gave a detailed account of their work to improve the management of IV Cannula. Internal Audit had reviewed their work and given significant assurance.
They are now seeking opportunity to obtain a gold team award.

Quarterly Directorate Governance report
This month the report was from Children and County Wide Community Services. The report detailed governance issues across the whole directorate covering a wide range of services. Patient feedback as well as incidents and areas of good practice are detailed. A small number of issues were discussed. The report shows that the directorate take clinical governance seriously and share good practice across the services.

Reports received.

- **The quality dashboard and the quality metrics in the IBR are considered at all meetings**
- **Safeguarding Children annual report.** The committee received a presentation detailing the work of the Safeguarding Team. This is an area of significant multi-agency work and covers all services, both

community and hospital. Assurance was provided that the service is developing well and implementing standards in all areas. A comprehensive summary is provided in the minutes of the meeting and the full report is available if board members wish to read it.

- **Evaluation of the HASU changes following the first 6 months of operation.** The paper provided assurance that the plans in place were working well. Patients were transferring back to HDFT following their acute treatment in Leeds or York. No patient feedback was included and ways to obtain it were discussed. A patient story was proposed.

Quality Priorities

The committee received a report on progress implementing the quality priority to **develop a sustainable model of acute care**. The report detailed the progress being made on consultant appointments.Development of a single point of care. Acute frailty model to be implemented in Spring 2020. Ongoing work on discharge and length of stay. Slow progress is being made on the hospital at night project. The report is available on diligent if board members wish to consider it.

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

No new risks

Matters for decision

No decisions required

Action Required by Board of Directors:

To note.

Harrogate and District NHS Foundation Trust

Terms of Reference

Quality Committee

1. Accountable to Board of Directors

The Quality Committee is a committee of the Board of Directors. As such it will, on behalf of the Board, contribute to setting strategy as this relates to quality; oversee arrangements for quality governance and seek assurances on the delivery of high quality care and regulatory compliance.

2. Purpose of the Committee

The Quality Committee is the primary mechanism by which the Board gains assurance regarding the safety and quality of services. Its purpose is to do the following in relation to quality:

- Seek assurance on the systems and processes in place to deliver high quality care on behalf of the Board of Directors;
- Provide scrutiny of the outcomes of these systems and processes in relation to quality on behalf of the Board of Directors;
- Provide direction on behalf of the Board of Directors regarding the delivery of the Trust's quality improvement priorities and strategic objectives in respect of quality.
- Provide oversight and seek assurance on regulatory compliance.

The role of the Audit Committee is to take a view as to whether the arrangements for gaining assurance are effective.

3. Responsibilities

The key responsibilities of the group are to:

- Set annual objectives and a plan of work;
- Report effectiveness against objectives and terms of reference at year end;
- Show leadership in setting a culture of continuous improvement in delivering high quality care;
- Oversee preparation of the Quality Report prior to approval by the Board of Directors and submission to NHSI;
- Review systems, processes and outcomes* in relation to:
    - Delivery of the Trust's objectives in relation to quality and annual quality improvement priorities;
    - Quality performance and outcome measures relating to fundamental care, including the impact of cost improvement plans;
    - Staff metrics that impact on quality i.e. staff vacancies, statutory and mandatory training, induction, appraisal and sickness;
    - CQC registration and compliance with fundamental standards in acute and community services;
    - Organisational learning as a result of incidents, SIRIs, complaints, concerns and claims;

  - Organisational learning and improvement as a result of patient and staff feedback from national and local surveys including FFT, and patient safety visits;
  - Organisational learning and improvement in compliance with best practice and quality standards as a result of audit, NICE publications, national inquiries and reviews relating to quality by DH arms-length bodies, regulators and professional bodies, inspections and peer reviews etc.
  - Research and development, quality improvement and innovation, including rapid process improvement workshops and delivery of CQUIN.
- Receive key reports for example:
  - Maternity screening report;
  - Health and Safety annual report;
  - Patient experience including complaints, concerns and compliments annual report;
  - Staff survey as it relates to the quality of care.

*Where possible, the Committee will consider assurance in relation to the four domains defined in NHSI's Well-led framework for governance reviews: guidance for NHS foundation trusts:

- Strategy and planning;
- Capability and culture;
- Process and structures;
- Measurement.

4. Membership

The membership comprises:

- Non-Executive Director (Chair)
- Non-Executive Director
- Non-Executive Director
- Chief Nurse
- Chief Operating Officer

At least one member of the Quality Committee will also be a member of the Audit Committee to ensure appropriate triangulation.

In addition the following individuals will be in attendance at meetings of the Quality Committee:

- Deputy Medical Director – Clinical Audit
- Deputy Director Partnerships and Innovations
- Deputy Director of Governance
- Head of Risk Management
- Clinical Director Children's and County Wide Community Care Directorate
- Clinical Director Long Term and Unscheduled Care Directorate
- Clinical Director Planned and Surgical Care Directorate
- Deputy Director – Improvement and Transformation
- Head of Midwifery

- Company Secretary
- Chief Nurse, Harrogate and Rural District Clinical Commissioning Group
- A Governor of the Trust (observer only)

Ad hoc attendance will be by invitation of the Chair.

5. Quorum

The meeting will be quorate when four members are in attendance to include a minimum of two NEDs.

6. Administrative support

The corporate directorate will provide administrative support to arrange meetings, prepare agendas, circulate papers and draft minutes including a register of attendance to be agreed with the chair of the meeting prior to circulation as described below. Papers will be made available a minimum of five days prior to scheduled meetings.

An action log will be maintained, and a log of items reviewed throughout each 12 month period.

7. Frequency of meetings

The meeting will be timetabled to take place monthly.

8. Communication

Minutes, including a register of attendance will be maintained. The draft minutes will be approved by the chair of the meeting and then shared with the members of the Committee and the Board of Directors. The draft minutes will be reviewed and the final record agreed at the next meeting.

9. Reporting

The Quality Committee will present an annual report to the Board of Directors outlining its work against its duties set out in the terms of reference. The Quality Committee will make recommendations to the Board of Directors on any area within its remit where action or improvement is required. Member's attendance at Quality Committee meetings will be disclosed in the Trust's Annual Report.

10. Review

The terms of reference will be reviewed annually.

11. Date

November 2019

NHS
Harrogate and District
NHS Foundation Trust

Council of Governors' Meeting

Minutes of the public Council of Governors' meeting held on 7 August 2019 at 17:45 hrs at the Pavilions of Harrogate, Great Yorkshire Showground, Harrogate, HG2 8NZ

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Present:	Angela Schofield, Chairman Sarah Armstrong, Non-Executive Director Dr Pam Bagley, Stakeholder Governor John Batt, Public Governor Angie Colvin, Corporate Affairs and Membership Manager Jonathan Coulter, Deputy Chief Executive/Finance Director Robert Cowans, Public Governor Clare Cressey, Stakeholder Governor Martin Dennys, Public Governor Sue Eddleston, Public Governor Emma Edgar, Staff Governor Andrew Forsyth, Interim Company Secretary Carolyn Heaney, Stakeholder Governor Samantha James, Public Governor Pat Jones, Public Governor Mikalie Lord, Staff Governor Cllr John Mann, Stakeholder Governor Doug Masterton, Public Governor Cllr Samantha Mearns, Stakeholder Governor Dr Christopher Mitchell, Public Governor Laura Robson, Non-Executive Director Steve Russell, Chief Executive Dr David Scullion, Medical Director Richard Stiff, Non-Executive Director Dave Stott, Public Governor Heather Stuart, Staff Governor Maureen Taylor, Non-Executive Director Chris Thompson, Non-Executive Director Steve Treece, Public Governor Lesley Webster, Non-Executive Director Angela Wilkinson, Director of Workforce and Organisational Development
In attendance:	2 members of the public Matthew Ackroyd, KPMG

1. Welcome and apologies for absence

Angela Schofield welcomed members of the public and introduced the newly elected Governors – Samantha James and Dave Stott, Public Governors for Harrogate and surrounding villages, Doug Masterton, Public Governor for Wetherby and Harewood, and Heather Stuart, Staff Governor, Nursing and Midwifery.

Apologies were received from Ian Barlow, Public Governor, Cath Clelland, Public Governor, Tony Doveston, Public Governor, Jill Foster, Chief Nurse, Rob Harrison, Chief Operating Officer, Dr Loveena Kunwar, Staff Governor, and Neil Lauber, Staff Governor.

2. Declarations of Interest

There were no further declarations of interest in addition to paper 2.

It was noted Jonathan Coulter and Chris Thompson were Directors of Harrogate Healthcare Facilities Management (HHFM), trading as Harrogate Integrated Facilities (HIF).

3. Minutes of the last meeting held on 1 May 2019

The minutes of the last meeting held on 1 May 2019 were agreed as a true and accurate record.

4. Matters arising and review of action log

Steve Russell referred to the Governor Briefing (Actions Update) circulated prior to the meeting which reflected an up to date position on the issues outstanding. The Action Log would be updated accordingly.

Item 1, wheelchairs – in addition to the briefing, Steve confirmed he had communicated direct with Cath Clelland regarding her review of one alternate wheelchair on 9 July. Heather Stuart suggested including children and young people in any future trial of wheelchairs.

Items 2-5 - complete.

Item 6, Trust-wide property strategy – complete. In addition to the briefing, Jonathan Coulter confirmed that further discussions regarding property would take place at the Board Workshop in a few weeks.

Mikalie Lord asked about exploring existing GP properties as part of primary care networks. Jonathan confirmed some primary care properties had been identified and a new Harrogate Public Sector Estates Group had been set up to look at sharing properties with the police and fire service in addition to primary care.

In response to Heather Stuart's question about whether the property strategy included the 0-19 Children's Services, Jonathan confirmed that each locality would be reviewed in relation to property and service provision, and discussions would take place with staff to ensure they were able to undertake their role.

Items 7-14, complete.

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Item 15 (to be renumbered as item 2 on the Action Log) would remain ongoing as a reminder to circulate presentations or provide hard copies at the meeting.

Item 16 (to be renumbered as item 3 on the Action Log), Integrated Board Report (IBR) – this item was expected to be completed by November.

Item 17 (to be renumbered as item 4 on the Action Log), Vacancy Plan – Steve Russell confirmed that a further updated vacancy plan would be circulated when additional information had been finalised. Clare Cressey requested recruitment timescales to be included in the update following the Rapid Process Improvement Workshop.

Item 18 - 20, complete.

Governors confirmed they found the Briefing very helpful in addition to the Action Log. It was agreed to upload this document to the website alongside the meeting agenda and papers.

5. Chairman's verbal update on key issues

Angela Schofield reflected on the Annual Members' Meeting and gave thanks to Angie Colvin and Andrew Forsyth for organising the event, to everyone who attended, and to Pat Jones who gave a presentation on behalf of the Council of Governors. Maureen Taylor & Sue Eddleston commented that the stands provided a good range of information. Steve Treece felt the timing of the meeting was better in July than September and Doug Masterton commented on the incredible contribution received from volunteers.

In respect of the arrangements for Governors' questions, Emma Edgar confirmed that following the meeting held on 17 July for Governors to discuss and agree the questions to be submitted to the Council of Governors, there had also been a number of questions submitted outside of the meeting and these had been answered via the Governors' email bulletin. Emma felt that this process was working well and it gave all Governors the opportunity to submit questions and receive a timely response. Emma and Angie Colvin would be working on a 'flowchart' style guidance document to inform Governors of the many different ways questions could be asked. It was also agreed that the questions and responses submitted outside of the meeting would also be uploaded to the website.

Angela thanked Emma for her help in leading this positive approach.

Angela reminded Governors that following the Governor Development Session in June, Steve Russell had suggested that Governors would receive a Chief Executive and Chairman's Update Report following the Board Workshop held every alternate month; she hoped Governors were finding this useful.

Angela confirmed the following seats would be included in the elections to commence in October:

- Public Governor for Harrogate and surrounding villages – one seat.
- Public Governor for Ripon and West District – one seat.
- Public Governor for Wetherby and Harewood – one seat.
- Staff Governor for Nursing and Midwifery – one seat.
- Staff Governor for Non-Clinical – one seat.

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There were some seats where Public Governors would be eligible for re-election if they chose to re-stand.

Angela summarised the key points raised from the 1:1's with Governors over recent months and thanked everyone for their contributions. These included:

- To review the induction process for new Governors including follow-ups at three and six months. There would be an opportunity for a small group of Governors to work with Angie Colvin on this review. Martin Dennys confirmed that he would like to be involved in this review.
- To provide reminders to Governors about the purpose of each scheduled meeting. This information was available in the Governors' Resource File, but in addition, a reminder would be included on the weekly Governors' email bulletin when referring to a scheduled meeting.
- Governors requested opportunities for informal 'get togethers'. It was agreed for Governors to arrange these themselves.
- Governors requested opportunities for more visits to services provided across the Trust. A number of visits had already been arranged prior to the scheduled Informal Governors' Briefings however numbers of attendees had been low. Governors were reminded of these arranged visits and to let Angie know if there were any further requests.
- To review the membership newsletter content and frequency.

In addition to the above points, Angela also mentioned there would be a review of the Non-Executive Directors' appraisal process and Angie had sent out a short questionnaire to Governors regarding future Saturday morning meetings which also included the suggestion to hold a future meeting in the North East.

There were no questions.

Actions:

- **Review Governor Induction process**
- **Review membership newsletter content and frequency**
- **Review of Non-Executive Directors' appraisal process**
- **Survey of Governors regarding future Saturday morning and North East meeting**

6. Update from the Interim Deputy Chair of Governors on Non-Executive Directors' Appraisals

Emma Edgar provided an update on the Non-Executive Directors' appraisals, including the Chairman. Emma had carried out seven appraisals in total, six with Angela Schofield for each Non-Executive Director and the Chairman's appraisal she carried out with Lesley Webster, Senior Independent Director. Feedback from Governors and Board colleagues had been requested prior to undertaking the appraisals but Emma had only received responses from six Governors. She was pleased to report that comments reflected on Non-Executive Directors being committed to their work and that they demonstrated support to the Council of Governors.

Following a detailed discussion about a range of issues with the current process, it was agreed that a review was required, particularly regarding anonymity of Governors' feedback.

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7. HDFT Constitution Review

Angela Schofield referred to Paper 7.0 which detailed a number of approvals required by the Council of Governors based on proposals made by the Constitution Review Group who met on 1 July. Angela summarised each proposal and received approval from the Council of Governors. Andrew Forsyth advised that the proposals would now go to the Trust Board for agreement before any changes were made.

On behalf of the Council, Angela thanked Emma Edgar for continuing as interim Deputy Chairman (proposed to be retitled Lead Governor) until 31 December 2019. Martin Dennys raised the term of office for an elected Deputy Chairman as a topic for discussion which Emma Edgar noted.

8. Report of Remuneration, Nominations and Conduct Committee

Angela Schofield summarised the report from the Remuneration, Nominations and Conduct Committee circulated prior to the meeting at Paper 8.0. There were no further comments and the Council of Governor noted the ongoing process to recruit two new Non-Executive Directors and approved the revised Terms of Reference referred to in the report.

9. Annual Report and Accounts 2018/19 (including the External Audit Assurance Report to the Council of Governors)

Matthew Ackroyd from KPMG presented the annual External Audit Report 2018/19, summarising the role of external auditor and the findings in the report which had been circulated prior to the meeting. He highlighted the following key messages:

- Financial Statements Audit – a clean unqualified audit opinion was issued to the Trust and the report concluded that the Annual Report and Annual Governance Statement were consistent with financial statements and complied with the Group Accounting Manual. The audit identified a couple of differences and some minor presentational changes however, these were not material to the overall opinion. There were also three 'amber' rated recommendations; one of which was the general ledger transfer however, KPMG acknowledged there were challenges across the NHS due to the introduction of a new finance and procurement system.
- Use of resources - the audit identified no significant issues identified at year-end and an unqualified use of resources opinion for 2018/19.
- Quality Report - the content of the Quality Report complied with the requirements set out within NHS Improvement's guidance and a clean limited assurance opinion was given on the two mandated indicators tested.

Angela Schofield invited questions from Governors.

Cllr John Mann asked for further clarification regarding the £3.865m unadjusted audit differences referred to on slide 2. This related to two items. Firstly the receipt of £1.2m charitable income where the Board and Audit Committee felt that it was appropriate to account for the income in 2018/19 as the formal commitment had been made in March. Secondly, the amount of £2.6m in respect of recoverable business rates. This was also included in the 2017/18 financial statements as the Board and Audit Committee were sufficiently confident that the amount would, in due course, be received. It was again included in the 2018/19 financial statements because there continued to be confidence that it would be received.

You matter most

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Mikalie Lord asked how this report compared with previous reports. Jonathan advised that the Trust had always received a clean opinion in the external audit report. Matthew highlighted that it was unusual for Trusts to have a clean opinion across the three audit domains; most Trusts would have at least one adjustable audit difference.

Doug Masterton referred to the clean limited assurance opinion on the two mandated indicators within the Quality Report. Angela confirmed that Governors could also be assured from a wide range of reports providing quality data, such as the IBR. Chris Thompson added that Internal Audit provided ongoing assurance and confirmed that Governors could gain this assurance by attending Audit Committee.

In relation to the £1.2m unadjusted audit difference concerning charitable income, Heather Stuart asked for clarification, in particular that the receipt of income was not at risk. Jonathan confirmed that the charitable income was income received directly to the Trust from a third party charitable source and not income donated through the Harrogate Hospital & Community Charity. He confirmed that the funding was not at risk; the issue raised through the audit was a matter of timing rather than certainty of receipt.

Laura Robson commented on the terminology of 'limited assurance' used in the report. She sought assurance from Matthew that this was nationally agreed terminology and he confirmed that a clean limited assurance was the best opinion the Trust could achieve.

Angela acknowledged the work of the Trust's Finance Team and thanked them on behalf of the Board and Council.

10. Chief Executive's Strategic and Operational Update, including Integrated Board Report (IBR)

Steve Russell presented his update to Governors which included a summary of the Trust's performance for Quarter 1 (April to June 2019), an update on the work with Harrogate and Rural District Clinical Commissioning Group, an update on some of the key people priorities, a look at the Trust's focus for Quarter 2 (July to September 2019), and some key areas of success and celebration.

The slides would be made available on the Trust's website at:
https://www.hdft.nhs.uk/about/council-of-governors/governors-meetings/

In response to Cllr John Mann's question regarding the downward trend of activity from Leeds Clinical Commissioning Group, Steve confirmed there had been changes made to referrals from GP practices that were part of Leeds CCG. The impact on HDFT was unintentional, but at this point had created a significant financial loss for the Trust. Discussions were taking place with colleagues in Leeds Trust and Leeds CCG to ensure that patients who wished to have treatment at Harrogate could continue to be referred to Harrogate rather than being referred to Leeds.

11. Audit Committee update on the External Auditor Performance

Chris Thompson referred to his report at Paper 11.0 circulated prior to the meeting and highlighted the following points:

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He confirmed that the Audit Committee considered the performance of the External Auditor in May following completion of the larger part of the 2018/19 external audit work. The External Audit Effectiveness Assessment demonstrated an average rating of 4.48 for 2019 (the maximum score was 5.0) compared with last year's average rating of 4.47. Chris noted that the assessment had taken place prior to the finalisation of the accounts, and there had been some issues in the intervening period. It had therefore been agreed that the evaluation would therefore be reconsidered at the September Audit Committee meeting.

Angela Schofield thanked Chris for his report and his reflective comments.

12. Question and Answer session for Governors and members of the public

Angela Schofield moved to the tabled questions submitted prior to the meeting. There were no questions from members of the public. Emma Edgar confirmed Governors had met on 17 July and everyone had the opportunity to discuss and agree the following questions to be submitted:

"We know that there are considerable waiting list issues with services such as Autism (2years) Paediatric Dental (1yr), how assured are Non-Executive Directors that there is sufficient attention being paid to managing waiting lists (in general) that would be deemed unacceptable, the potential impact on patients and that there is a more robust strategy going forward?"

In addition to the formal response provided at appendix 1, Laura Robson provided additional assurance that discussions at Board continued about that this topic and that the data provided in the IBR and Quality Dashboard was scrutinised regularly at Quality Committee.

Mikalie Lord highlighted the impact this had on patients and asked what information was being passed to patients to manage their expectations.

Laura confirmed that Non-Executive Directors had visited the autism service; they had discussed how the service was managing the waiting list and how this was being fed back to the patients.

Steve highlighted the rapid improvement week described in the formal response and confirmed that the service was being open with patients about the waiting list.

With regards to dentistry, there was further work ongoing to reduce waiting times and, in response to Mikalie's concerns, Steve confirmed the issues were assessed through the Directorate Risk Register.

"In the context of current plans for the UK to leave the EU on 31 October, what assurance can the Trust give that appropriate plans are in place to ensure continuity of supply in relation to all medicines and medical supplies in the event of a no-deal scenario and that patients will not be negatively affected?"

In addition to the formal response at appendix 1, Steve Russell confirmed that the Board would continue be updated with any guidance that was received.

"Can the Non-Executive Directors assure the public how the Trust continuously improves services in a responsive manner following patient feedback, complaints and

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serious incidents; it would help to have regular supporting statistics, examples of improvements and typical elapsed times from being raised to embedding change."

In addition to the formal response at appendix 1, Richard Stiff commented that the Trust's process around complaints compared to that of local government. He acknowledged concerns with the timeline and the complexity of investigating complaints. Richard added that the Trust should not overlook the wide range of feedback channels received, many that were significantly positive.

Emma Edgar expressed her concerns from the perspective of an investigator regarding the length of time it was taking to hear back after completing a report.

Steve Russell confirmed some initial changes had taken place prior to a scheduled rapid process improvement workshop in September.

"How are the Non-Executive Directors assured regarding the Trust's preparations for a significant increase in influenza cases in the coming winter period, in light of the current experience in Australia, which tends to be repeated in the UK?"

In addition to the formal response at appendix 1, Maureen Taylor expressed the Board's concerns about the vaccination rate for frontline workers and noted that this would be discussed further at the August Board workshop.

Dr David Scullion confirmed that one out of three unimmunised medical staff was unacceptable and he would be working hard to influence an improvement this winter.

Following a detailed discussion about the multiple reasons why someone would not choose to be vaccinated, Steve Russell confirmed that the Trust would be encouraging an improvement in take up by focussing on culture and the use of peer vaccinators to encourage uptake.

"Can a study be undertaken to look at the possibility of adding A&E, Minor Injuries Units and Medical Centres to the App for the Harrogate area and possibly encouraging York, Leeds and Bradford to add their facilities to the App?"

John Batt had submitted the final question; however, he had to leave the meeting before it was raised. He expressed he was dissatisfied with the response in appendix 1 however, it was agreed by fellow Governors that the response was final.

The formal responses to each question are available on the Trust's website at:

https://www.hdft.nhs.uk/about/council-of-governors/governors-meetings/

Angela thanked Governors for their questions and hoped they had found the discussion helpful in addition to the formal response document which had been provided.

13. Any other relevant business not included on the agenda

There were no other items of business.

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14. Member Evaluation

Angela Schofield sought views about the meeting.

Feedback included the importance of the agenda running to time. It was noted that members of the public had left before questions at item 12 therefore Governors discussed the option to rearrange the agenda and have the private session after the public meeting. Governors liked the venue and seating arrangements. It was the first time a formal response to the submitted questions had been provided and Governors found this helpful. It was agreed to commence the public meeting at 5.15pm with the Chief Executive Update and Questions and then continue with the remaining business. The private meeting would commence at 7.30pm and close at 8pm.

15. Close of meeting

Angela Schofield closed the meeting, thanking everyone for attending and confirmed the next public meeting would take place on Wednesday, 6 November 2019 (venue to be confirmed).

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Harrogate and District NHS Foundation Trust

CONSTITUTION OF HARROGATE AND DISTRICT NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

Updated in line with the requirements of the Health and Social Care Act 2012

With effect from 1 August 2018

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1. Interpretation and definitions

1.1. Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

1.2. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

1.3. In this constitution:

"the 2006 Act"	is the National Health Service Act 2006;
"the 2012 Act"	is the Health and Social Care Act 2012;
"Accounting Officer"	means the person who from time to time discharges the function specified in section 25(5) of Schedule 7 to the 2006 Act;
"Annual Members' Meeting"	is defined in paragraph 15 of this constitution;
"area of the Trust"	means the areas specified in Annex A;
"Board of Directors"	means the Board of Directors as constituted in accordance with this constitution;
"CCGs"	means Clinical Commissioning Groups;
"Chairman"	means the individual appointed by the Council of Governors to provide leadership to and chair meetings of the Board of Directors and the Council of Governors;
"Company Secretary"	means the individual appointed to perform the duties of the Secretary to the Trust as defined in section 17 of this constitution;
"constitution"	means this constitution and all annexes to it;
"Council of Governors"	means the Council of Governors as constituted in accordance with this constitution;
"~~Deputy Chairman of~~ Lead Governor	means the person appointed to preside over

~~Governors~~ “”	meetings of the Council of Governors in the absence of the Chairman and Vice Chairman.
“Director”	means a member of the Board of Directors;
“elected Governors”	means those Governors elected by the public constituencies and the classes within the staff constituency;
“financial year”	means each successive period of twelve months beginning with 1 April;
"Governor"	means a member of the Council of Governors and either being a Public Governor, Staff Governor or Stakeholder Governor;
“Licence”	means the Trust’s licence granted by Monitor under the 2012 Act;
"Medical Practitioners' Staff Class"	means the staff class of the staff staff constituency defined in paragraph 7.3.3 of this constitution;
“NHS Improvement” (formally known as Monitor)	is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act;
"Nursing and Midwifery Staff Class"	means the staff class of the staff constituency defined in paragraph 7.3.2 of this constitution;
"Other Clinical Staff Class"	means the staff class of the staff constituency defined in paragraph 7.3.4 of this constitution;
"Non-Clinical Staff Class"	means the staff class of the staff constituency defined in paragraph 7.2.5 of this constitution;
“Local Authority Governor”	means a member of the Council of Governors appointed by one or more local authorities whose area includes the whole or part of the area of the Trust;
“member”	means a member of the Trust;
“the Trust”	means Harrogate and District NHS Foundation Trust;

	"Public Governor"	means a member of the Council of Governors elected by members of the public constituencies;
Trust		
	"Senior Independent Director"	means the individual appointed by the Board to act as the Senior Independent Director in accordance with section 16.5 of the constitution;
	"Staff Governor"	means a member of the Council of Governors elected by the members of the relevant class within the staff constituency;
	"Stakeholder Governor"	means those members of the Council of Governors appointed by the appointing organisations;
	"Vexatious Complainant"	a definition can be found within the Trust's Making Experiences Count Policy;
	"Vice Chairman"	means the individual appointed by the Council of Governors, to chair in the absence of the Chairman, meetings of the Board of Directors and the Council of Governors.

2 Name

2.1 The name of the foundation Trust is Harrogate and District NHS Foundation Trust (the Trust).

3 Principal purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry out activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4 Powers

4.1 The powers of the Trust are set out in the 2006 Act, subject to any restrictions in its Licence.

4.2 In particular it may:

4.2.1 acquire and dispose of property;

4.2.2 enter into contracts;

4.2.3 accept gifts of property (including property to be held on Trust for the purposes of the Trust or for any purposes relating to the health service); and,

4.2.4 employ staff.

4.3 Any power of the Trust to pay remuneration and allowances to any person includes the power to make arrangements for providing, or securing the provision of, pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay).

4.4 The Trust may borrow money for the purposes of or in connection with its functions subject to any restrictions imposed by NHS Improvement from time to time.

4.5 The Trust may invest money (other than money held by it as Trustee) for the purposes of or in connection with its functions subject to any guidance provided by NHS Improvement. The investment may include investment by:

4.5.1 forming, or participating in forming bodies corporate;

4.5.2 otherwise acquiring membership of bodies corporate.

4.6 The Trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.

4.7 The Trust may raise charitable funds and in doing so, appeal for any contribution, donation, grant, gift money or property.

5 Commitments

5.1 The Trust shall exercise its functions effectively, efficiently and economically.

5.2 Representative membership

5.2.1 The Trust shall at all times endeavour to procure membership that, taken as a whole, is representative of those eligible for membership, and in deciding which areas are to be areas of the Trust, have regard to the need for those eligible for such membership to be representative of those to whom the Trust provides goods and services. The Trust shall at all times have in place and pursue a Membership Development Strategy which shall be approved by the Council of Governors, and which shall be reviewed by them from time to time, and in any event, at least every three years.

5.2.2 The Council of Governors shall present to each Annual Members' Meeting:

5.2.2.1 a report on steps taken to procure that, taken as a whole, the actual membership of its constituencies is representative of those eligible for such membership;

5.2.2.2 the progress of a Membership Development Strategy; and,

5.2.2.3 any changes to the Membership Development Strategy.

5.3 Co-operation with external organisations

5.3.1 In exercising its functions the Trust shall co-operate with other NHS bodies (as defined in Section 275 of the 2006 Act) including the National Institute for Health and Clinical Excellence, NHS Digital, Local Authorities, NHS Improvement, the Care Quality Commission and with other non-health organisations, both statutory and voluntary.

5.4 Respect for rights of people

5.4.1 In conducting its affairs, the Trust shall respect the rights of members of the community it services, its employees and people dealing with the Trust as set out in the Charter of

Fundamental Rights of the European Union and the NHS Constitution.

5.5 Openness

5.5.1 In conducting its affairs, the Trust shall have regard to the need to provide information to members and conduct its affairs in an open and accessible way.

6 Framework

6.1 The affairs of the Trust are to be conducted by the Board of Directors, the Council of Governors and the members in accordance with this constitution. The members, the Council of Governors and the Board of Directors are to have the roles and responsibilities set out in this constitution.

7 Membership and constituencies

7.1 The members of the Trust are those individuals whose names are entered in the membership database. Every member is either a member of one of the public constituencies or a member of one of the classes of the staff constituency. Subject to this constitution, membership is open to any individual who:

7.1.1 is 16 years of age and over; and

7.1.2 is entitled under this constitution to be a member of a public constituency or a member of the appropriate class within the staff constituency as applicable; and

7.1.3 if applying to be a member of a public constituency, has completed a public membership application form; or

7.1.4 if applying to be a member of a class within the staff constituency, chooses to opt in to the staff membership scheme.

7.2 Public constituencies

7.2.1 There are six public constituencies covering the area of the Trust as set out in Annex A. Membership of each of the public constituencies is open to individuals:

7.2.1.1 who live in an area of the Trust;

7.2.1.2 who are not eligible to be members of the staff constituency;

7.2.1.3 who meet the criteria and have completed the application referred to in paragraph 7.1 above; and

7.2.1.4 who are not otherwise disqualified from membership under paragraph 8 of this constitution.

7.2.2 The minimum number of members in each of the public constituencies is:

200 in Harrogate and surrounding villages;

120 in Ripon and West District;

120 in Knaresborough and East District;

120 in Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley Wards;

100 in the rest of North Yorkshire and York; and

50 in the Rest of England.

7.2.3 Those individuals who live in an area of the Trust are referred to collectively as a public constituency.

7.3 Staff constituency

7.3.1 The staff constituency is to be divided into four classes of individuals as follows:

The Nursing and Midwifery Staff Class;

The Medical Practitioners' Staff Class;

The Other Clinical Staff Class; and

The Non-Clinical Staff Class.

The classes are collectively referred to as the staff constituency. In the case of employment covering a dual role, the primary appointment will determine the relevant class of the staff constituency.

7.3.2 The members of the Nursing and Midwifery Staff Class are individuals who are members of the staff constituency whose regulatory body falls within the remit of the Council for Healthcare Regulatory Excellence established by section 25 of the NHS Reform and Health Care Professions Act 2002 and who are registered with the Nursing and Midwifery Council, and unregistered nursing staff who are employed by the Trust.

7.3.3 The members of the Medical Practitioners' Staff Class are individuals who are members of the staff constituency who are fully registered persons within the meaning of the Medical Act 1983 or the Dental Act 1984.

7.3.4 The members of the Other Clinical Staff Class are individuals who are members of the staff constituency (other than nurses or midwives referred to in paragraph 7.3.2 above) whose regulatory body falls within the remit of the Council for Healthcare Regulatory Excellence established by section 25 of the NHS Reform and Health Care Professions Act 2002, or are employed by the Trust to carry out associated clinical duties to support clinical staff.

7.3.5 The members of the Non-Clinical Staff Class are individuals who are members of the staff constituency who do not come within paragraphs 7.3.2, 7.3.3 and 7.3.4 above.

7.3.6 Members of the staff constituency are to be individuals who:

7.3.6.1 are employed by the Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months; or,

7.3.6.2 have been continuously employed by the Trust for at least 12 months; and,

7.3.6.3 are not disqualified from membership under paragraph 8 below; and,

7.3.6.4 have been invited by the Trust to become a member of the relevant class of the staff constituency and have informed the Trust they wish to be a member.

7.3.7 The minimum number of members in each class of the staff constituency is:

150 will be registered in the Nursing and Midwifery Staff Class;

15 in the Medical Practitioners' Staff Class;

50 in the Other Clinical Staff Class; and

100 in the Non-Clinical Staff Class.

7.3.8 A person who is eligible to be a member of one of the classes of the staff constituency may not become or continue as a member of the public constituencies and may not become or continue as a member of more than one staff class.

8 Disqualification from membership

8.1 A person may not be a member of the Trust:

8.1.1 If, in the opinion of the Council of Governors after following proper procedures as required by the Trust's Standing Orders, there are reasonable grounds to believe that they are likely to act in a way detrimental to the interests of the Trust;

8.1.2 If within the last five years they have perpetrated a serious incident of violence towards any of the Trust's facilities, employees or volunteers in association with their employment as defined in the Trust's Violence and Aggression Policy; or

8.1.3 If they are not eligible to be a member in accordance with paragraphs 7.2 and 7.3 of this constitution.

9 Termination of membership

9.1 A member shall cease to be a member if:

9.1.1 they resign by notice to the Foundation Trust Office;

9.1.2 they die;

9.1.3 they are disqualified from membership by paragraph 8;

9.1.4 being a member of a public constituency, they cease to fulfil the requirements of paragraph 7.2; or,

9.1.5 being a member of the staff constituency, they cease to fulfil the requirements of paragraph 7.3.

9.2 Upon ceasing to be a member, any benefits attaching to membership cease immediately.

10 The role of members

10.1 The role of members is to demonstrate their support to the Trust and should they wish to, and be eligible, stand for election to be a Public Governor or Staff Governor on the Council of Governors.

10.2 To vote on whether to approve amendments to the constitution in relation to the powers and duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) and to take such other part in the affairs of the Trust as is provided in this constitution.

10.3 The surpluses or any profits of the Trust are not to be distributed either directly or indirectly in any way at all among members of the Trust.

10.4 Members will receive treatment by the Trust on exactly the same basis as any other NHS patient.

11 The Council of Governors

11.1 The Trust is to have a Council of Governors. It is to consist of elected Public and Staff Governors and appointed Stakeholder Governors.

11.2 The Council of Governors of the Trust is to comprise:

11.2.1 Thirteen Public Governors, which must be more than half the total membership of the Council of Governors, are to be elected by the public constituencies as follows:

Area 1 – Harrogate and surrounding villages (five Governors);

Area 2 – Ripon and West District (two Governors);

Area 3 – Knaresborough and East District (two Governors);

Area 4 – Wetherby and Harewood wards and Alwoodley, Adel and Wharfedale and Otley and Yeadon wards (two Governors);

Area 5 – The Rest of North Yorkshire and York (one Governor); and

Area 6 – the Rest of England (one Governor).

11.2.2 Five Staff Governors from each of the following four staff classes are to be elected as follows:

Medical Practitioners' Staff Class (one Governor);

Nursing and Midwifery Staff Class (two Governors);

Other Clinical Staff Class (one Governor); and,

Non-Clinical Staff Class (one Governor).

11.2.3 Six appointed Stakeholder Governors from each of the following:

11.2.3.1 Patient Experience Stakeholder Governor;

11.2.3.2 North Yorkshire County Council;

11.2.3.3 Harrogate Borough Council;

11.2.3.4 A Governor appointed by a local university or research institution;

11.2.3.5 A Voluntary Organisation Governor appointed by a local voluntary organisation; and,

11.2.3.6 A Governor appointed by Harrogate Healthcare Facilities Management Limited.

11.3 Composition of the Council of Governors, subject to the 2006 Act, shall seek to ensure that:

11.3.1 the interests of the community served by the Trust are appropriately represented; and,

11.3.2 the level of representation of the public constituencies, the staff constituency and the appointed Stakeholder Governors strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs.

11.4 Elected Governors

11.4.1 Subject to the composition of the Council of Governors, members of the public constituencies may elect any of their number to be Public Governors for that constituency. Members of each of the classes in the staff constituency may elect any of their number to be Staff Governors for that class.

11.4.2 If contested, the elections will take place by secret ballot in accordance with the Trust's election rules using the single transferable vote system.

11.4.3 The model election rules for the Council of Governors, which govern the elections for elected Governors, are set out in Annex B to this constitution. Any subsequent variation of the model election rules shall not constitute a variation of the terms of this constitution for the purposes of paragraph 27 of this constitution.

11.5 Appointed Stakeholder Governors

11.5.1 The organisations set out in 11.2.3 above shall, on request, furnish the Trust the names of Governors appointed to serve and be responsible for replacement as necessary.

11.6 Council of Governors – tenure

11.6.1 Elected Governors:

11.6.1.1 shall normally hold office for a period of three years;

11.6.1.2 subject to the next sub-paragraph, are eligible for re-election after the end of that period;

11.6.1.3 may not hold office for more than nine years in total or three terms of office; and

11.6.1.4 An elected Governor who has fulfilled their term of office may not return as a Stakeholder Governor without a break of one term (three years).

cease to be a Governor if they:

11.6.1.5 cease to hold office;

11.6.1.6 cease to be a member of the public constituency to which they were elected, or;

11.6.1.7 cease to be a member of the class of the staff constituency to which they were elected.

11.6.2 Appointed Stakeholder Governors:

11.6.2.1 shall normally hold office for a maximum period of three years commencing from the date of their appointment;

11.6.2.2 subject to the next sub-paragraph, are eligible for re-appointment after the end of that period;

11.6.2.3 may not hold office for longer than nine years in total or three terms of office; and

11.6.2.4 shall cease to hold office if the appointing organisation terminates their appointment.

11.7 ~~Deputy Chairman~~Lead Governor of the Council of Governors

11.7.1 The Council of Governors shall elect a ~~Deputy Chairman~~Lead Governor from amongst the elected Governors. The ~~Deputy Chairman~~ Lead Governor shall preside in the absence of the Chairman and Vice Chairman. The Council of Governors shall operate its own procedure for electing the ~~Deputy Chairman~~ Lead Governor.

11.8 Ineligibility to be a Governor

11.8.1 A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so if:

11.8.1.1 they have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out regulated activity or providing a service elsewhere which, if provided in England would be a regulated activity;

11.8.1.2 they are a Director of the Trust, or a Governor or Director of another NHS Foundation Trust;

11.8.1.3 they are a member who shares the same household as a member of the Board of Directors of the Trust;

11.8.1.4 they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

11.8.1.5 they have made a composition or arrangement with, or granted a trust deed for, their creditors and have not been discharged in respect of it;

11.8.1.6 they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

11.8.1.7 they have within the preceding two years been dismissed from any paid employment with a health service body for reasons considered to be inappropriate by this Trust;

11.8.1.8 they are a person whose tenure of office as the Chairman or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

11.8.1.9 they have had their name removed, by a direction under paragraph 10 of the National Health Service (Performers Lists) Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere), and has not subsequently had their name included in such a list;

11.8.1.10 they are not by reason of their health capable of properly performing tasks which are intrinsic to the office for which they are elected or appointed;

11.8.1.11 they are a vexatious complainant of the Trust, as defined by Trust policy;

11.8.1.12 they are a vexatious litigant of the Trust as defined by Trust policy;

11.8.1.13 they are a family relation or occupant of the same household of a person who is an existing Governor of the Trust;

11.8.1.14 any amount properly owing to the Trust by them remains outstanding without good cause;

11.8.1.15 they do not, or cease to, fulfil the eligibility requirements as set out in this constitution.

11.9 Termination of office and removal of Governors

11.9.1 A person holding office as a Governor shall immediately cease to do so if:

11.9.1.1 they resign by notice in writing to the Chairman;

11.9.1.2 they fail to attend half of the Council of Governor meetings in any financial year, unless the other Governors are satisfied that:

11.9.1.2.1 the absences were due to reasonable causes; and

11.9.1.2.2 they will start attending meetings of the Trust again within such a period as the Council of Governors consider reasonable,

11.9.1.3 in the case of an elected Governor, they cease to be a member of the constituency or class of the constituency by whom they were elected.

11.9.1.4 in the case of an appointed Stakeholder Governor the appointing organisation terminates their appointment;

11.9.1.5 without good reason they have failed to undertake any training which the Council of Governors or Trust requires Governors to undertake;

11.9.1.6 they have failed to sign and deliver to the Foundation Trust Office a statement in the form required by the Council of Governors confirming acceptance of the code of conduct for Governors;

11.9.1.7 they refuse to sign the declaration form that they are a member of one of the public constituencies or one of the classes of the staff constituency as the case may be and are not prevented from being a member of the Council of Governors;

11.9.1.8 their name has been placed on a register of Schedule 1 offenders pursuant to the Sex Offences Act 2003 and/or the Children and Young Persons Act 1933 and the conviction is not spent under the Rehabilitation of Offenders Act 1974;

11.9.1.9 they are removed from the Council of Governors by a resolution approved by a majority of 75% (of the remaining Governors) at a quorate meeting of

the Council of Governors . The Governor would be permitted to address the Council of Governors in person if they wish to do so but must withdraw from the discussion, decision and voting on the resolution. The Council of Governors would consider a resolution to remove a Governor on the grounds that:

11.9.1.9.1 they have committed a serious breach of the code of conduct, or;

11.9.1.9.2 they have acted in a manner detrimental to the interests of the Trust which would undermine public confidence; and,

11.9.1.9.3 the Council of Governors considers that it is not in the best interests of the Trust for them to continue as a Governor.

11.9.2 Special Provisions relating to Termination of Governors' Tenure

11.9.2.1 Any complaint or concern made in respect of a Governor on any of the grounds set out in the Constitution shall be dealt with in line with the Procedure for Management of Governor Conduct Concerns.

11.9.2.2 At any time, the Chairman is authorised to take such interim measures as may be immediately required, including the exclusion of the Governor concerned from a meeting or suspension from duties, on the basis that such measures are necessary to:

11.9.2.2.1 Enable an effective investigation to be undertaken into any concern or complaint about a Governor;

11.9.2.2.2 Address or prevent any significant disruption to

the effective operation of any part of the Trust;

11.9.2.2.3 Manage risk to the health or wellbeing of a Governor, employee, volunteer or patient of the Trust;

11.9.2.2.4 Protect the reputation of the Trust or safeguard public confidence in the Trust;

11.9.2.2.5 Give effect to a proposal by the Council to impose a sanction on a Governor.

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11.10 Vacancies amongst Governors

11.10.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply:

11.10.1.1 where the vacancy arises amongst the appointed Stakeholder Governors, the Chairman shall request that the appointing organisation appoint a replacement to hold office for the remainder of the term of office;

11.10.1.2 where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty either:

11.10.1.2.1 to call an election within six months, provided that the period of the vacancy exceeds six months; or,

11.10.1.2.2 to invite the next highest polling eligible candidate for that seat at the most recent election, who is willing to take office to fill the seat until the next annual election, at which time the seat will become vacant and subject to election for any un-expired period of the term of office.

11.10.1.3 If no-one is available under 11.10.1.2.2, and the vacancy is for three months or less, the seat will remain vacant until the next scheduled election.

11.11 Expenses and remuneration of Governors

11.11.1 The Trust may pay travelling and other expenses to Governors at such rates as it decides.

11.11.2 Governors are not to receive remuneration.

11.11.3 The Chairman will agree separate arrangements with each appointing organisation in 11.2.3 to cover the reimbursement costs of the appointed Stakeholder Governor.

11.12 Disclosure of interests

11.12.1 Any Governor who has a material interest in a matter as defined in Annex E and below shall declare such interest to the Council of Governors and it shall be recorded in a register of interests. Further guidance is also available from the Trust's Conflicts of Interest Policy. The Governor in question:

11.12.1.1 shall not be present except with the permission of the Council of Governors in any discussion of the matter; and,

11.12.1.2 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

11.12.2 Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Governors, in accordance with section 11.9.1.

11.12.3 A material interest, as defined in Annex E, is a matter of any interest held by a Governor, their spouse or partner, or member of their immediate family, in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust. The exceptions which shall not be treated as material interests are as follows:

11.12.3.1 shares not exceeding 1% of the total shares in issue held in any company whose shares are listed on any public exchange;

11.12.3.2 an employment contract held by Staff Governors;

11.12.3.3 an employment contract with a Local Authority;

11.12.3.4 an employment contract with an educational establishment (a university or research institute) and

11.12.3.5 a contract held with a voluntary organisation.

11.12.4 An elected Governor may not vote at a meeting of the Council of Governors unless, before attending their first meeting, they have made a declaration in the form specified by the Council of Governors that they are a member of a public constituency or a member of the classes of the staff constituency and are not prevented from being a Governor of the Council of Governors. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors.

12 Roles and responsibilities of the Council of Governors

12.1 The general duties of the Council of Governors are:

12.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors;

12.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public;

12.1.3 to appoint or remove the Chairman and the other Non-Executive Directors;

12.1.4 to approve an appointment (by the Non-Executive Directors) of the Chief Executive;

12.1.5 to appoint the ~~Deputy Chairman~~Lead Governor of the Council of Governors;

12.1.6 to decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and Non-Executive Directors;

12.1.7 to appoint or remove the Trust's external auditor selected from an approved list put forward by the Board of Directors;

12.1.8 to consider the annual accounts, any report of the external auditor on them and the annual report;

12.1.9 to provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Trust's forward planning;

12.1.10 to respond as appropriate when consulted by the Board of Directors in accordance with this constitution;

12.1.11 to undertake such functions as the Board of Directors shall from time to time request and which the Council of Governors shall agree;

12.1.12 to prepare, and from time to time to review, the Membership Development Strategy, its policy for the composition of the Council of Governors and of the Non-Executive Directors;

12.1.13 to require one or more Directors to attend a meeting of the Council of Governors for the purpose of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust or Directors' performance);

12.1.14 to approve any merger, acquisition, separation or dissolution application in respect of the Trust before the application is made to NHS Improvement and the entering into of any significant transactions;

12.1.15 to vote on whether to approve the referral of a question by a Governor to any panel appointed by NHS Improvement; and

12.1.16 to approve any proposals to increase by 5% or more of the Trust's proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England. The proposal may be implemented only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

12.2 The Council of Governors will conduct its business at meetings held in accordance with this constitution.

12.3 All Governors will adhere to the policies and procedures of the Trust, acting in the best interest of the Trust at all times.

12.4 The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

12.5 Any amendments to the constitution in relation to the powers or duties of the Council of Governors (or otherwise in respect of the role that the Council of Governors has as part of the Trust) must be put to the vote of the members and approved at the Annual Members' Meeting in accordance with paragraphs 27.3 and 27.4 of this constitution.

13 Meetings of the Council of Governors

13.1 The Chairman of the Trust, or in his absence, the Vice Chairman of the Trust, or in exceptional circumstances in the absence of both the Chairman and Vice Chairman, the ~~Deputy Chairman~~ Lead Governor of the Council of Governors shall preside at a meeting of the Council of Governors.

13.2 Where a conflict of interest arises for the Chairman and Vice Chairman, the ~~Deputy Chairman~~ Lead Governorof the Council of Governors shall chair that element of the meeting. In the absence of the ~~Deputy Chairman~~Lead Governor, 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.

13.3 Meetings of the Council of Governors are to be open to members of the public except in the following circumstances:

13.3.1 during the consideration of any material or discussion in relation to a named person employed by or proposed to be employed by the Trust;

13.3.2 during the consideration of any material or discussion in relation to a named person who is, or has been, or is likely to become a patient of the Trust, or a carer in relation to such a patient; and,

13.3.3 during the consideration of any matter which, by reason of its nature, the Council is satisfied should be dealt with on a confidential basis.

13.4 The Chairman may exclude any person present from a meeting of the Council of Governors if they are interfering or preventing proper conduct of a meeting. In addition the Chairman may exclude any person present from a meeting of the Council of Governors for a breach of the Standing Orders relating to the conduct of meetings.

13.5 For the purposes of obtaining information about the Trust's performance of its functions, or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

13.6 The Council of Governors is to meet at least four times per year, three of which will be general meetings and one the Annual Members' Meeting.

13.7 At an Annual Members' Meeting, within six months of the end of the financial year, the Council of Governors are to receive and consider the annual accounts, any report of the external auditor on them and the annual report, see 12.1.8.

13.8 The Council of Governors is to adopt its own Standing Orders for its practice and procedure, in particular for its procedure at meetings, and these shall be in accordance with Annex D.

13.9 A Governor, whether elected to the Council of Governors by a public constituency, elected by one of the classes of the staff constituency or nominated as a Stakeholder Governor, may not vote at a meeting of the Council of Governors unless, within one month of election or appointment, he has made a declaration of eligibility in the form set out at Annex C stating which constituency or section he is a member of and is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 to the 2006 Act or under this constitution.

14 Council of Governors – referral to the Panel

14.1 In this paragraph, the Panel means a panel of persons appointed by NHS Improvement to which a governor of an NHS Foundation Trust may refer a question as to whether the Trust has failed or is failing:

14.1.1 to act in accordance with its constitution; or

14.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

14.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors in attendance at a quorate meeting vote to approve the referral.

15 Annual Members' Meeting

15.1 The Trust is to hold an annual meeting of its members (Annual Members' Meeting) within six months of the end of each financial year. The Annual Members' Meeting shall be open to members of the public.

15.2 At the Annual Members' Meeting the Council of Governors shall present to the members (and in respect of presenting the documents referred to in sub-paragraphs 15.2.1 to 15.2.4, at least one member of the Board of Directors must be in attendance):

15.2.1 the annual accounts;

15.2.2 any report of the external auditor;

15.2.3 any report of any other external auditor of the Trust's affairs;

15.2.4 the annual report;

15.2.5 forward planning information for the next financial year;

15.2.6 a report on steps taken to secure that (taken as a whole) the actual membership of its public constituencies is representative of those eligible for such membership;

15.2.7 the progress of the Membership Development Strategy;

15.2.8 subject to 15.5 below, any proposed changes to the constitution for the composition of the Council of Governors and of the Non-Executive Directors;

15.2.9 a report on the activities of the Remuneration, Nominations and Conduct Committee within the previous year; and

15.2.10 the results of elections and appointment to the Council of Governors.

15.3 The Council of Governors will invite the external auditor to the Annual Members' Meeting.

15.4 Minutes of every Annual Members' Meeting, of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept. Minutes of meetings will be taken at the next meeting and signed by the Chairman of that meeting. The signed minutes will be conclusive evidence of the events of the meeting.

15.5 Any amendments to the constitution in relation to the powers or duties of the Council of Governors (or otherwise in respect of the role that the Council of Governors has as part of the Trust) must be put to the vote of the members and approved at the Annual Members' Meeting in accordance with paragraphs 27.3 and 27.4 of this constitution.

16 Board of Directors

16.1 The Trust shall have a Board of Directors. It shall comprise of Executive and Non-Executive Directors.

16.1.1 Non-Executive Directors:

16.1.1.1 a Chairman, who is to be appointed by the Council of Governors; and,

16.1.1.2 a minimum of six Non-Executive Directors who are to be appointed by the Council of Governors.

16.1.2 Executive Directors:

16.1.2.1 a Chief Executive who is to be appointed by the Non-Executive Directors, subject to the approval of the Council of Governors;

16.1.2.2 the Chief Executive shall be the Accounting Officer;

16.1.2.3 a Finance Director;

16.1.2.4 a registered medical practitioner or a registered dentist (within the meaning of the Dentists' Act 1984);

16.1.2.5 a registered nurse or a registered midwife;

16.1.2.6 Two Executive Directors.

16.1.2.7 a Deputy Chief Executive who will be one of the above.

16.1.3 The Non-Executive Directors and Chief Executive will establish and set the Terms of Reference for a Remuneration and Nominations Committee for the appointment of Executive Directors. The committee should consist of the Chairman, the Chief Executive and other Non-Executive Directors. The removal of an Executive Director is subject to the application of the appropriate Trust policies and procedures.

16.1.4 Only members of the public constituencies who are not disqualified by virtue of paragraph 11.8.1 are eligible for appointment as a Non-Executive Director.

16.2 Appointment and removal of Non-Executive Directors

16.2.1 Non-Executive Directors (including the Chairman) are to be appointed by the Council of Governors. Removal of the Chairman and other Non-Executive Directors shall require the approval of 75% of the members of the Council of Governors at a quorate meeting.

16.2.2 The Council of Governors will establish and set the terms of reference for a Remuneration, Nominations and Conduct Committee. The Committee will normally be chaired by the Chairman. Where the Chairman has a conflict of interest, for example when the Committee is considering the Chairman's re-appointment or remuneration, the Committee will normally be chaired by the ~~Deputy Chairman of Governors~~Lead Governor.

16.2.3 That committee will recommend to the full Council of Governors no more than one individual per Non-Executive vacancy for appointment to the Board of Directors.

16.2.4 The Board of Directors will identify the skills, experience and knowledge required from time to time of any vacant post of Non-Executive Directors (including the Chairman). The Board of Directors will draw on advice from external sources as necessary.

16.2.5 The Council of Governors will have responsibility for the handling of all further aspects of the recruitment process, including any appointment.

16.2.6 The Trust shall publicly advertise the posts to be filled where determined by the Remuneration, Nominations and Conduct Committee on the basis of performance or when a Non-Executive Director is approaching their final term of office.

16.2.7 A long list for consideration will be identified by the Remuneration, Nominations and Conduct Committee. Only those candidates meeting the skills and experience agreed by the Board of Directors will be eligible for appointment.

16.2.8 For the purpose of considering the appointment of Non-Executive Directors the interview panel will include the Chairman, three Governors, at least one of whom will be a Public Governor, an independent external assessor and the Chief Executive, acting in an ex-officio capacity. The Chief Executive and the independent external assessor have no vote.

16.2.9 For the purpose of considering the appointment of the Chairman of the Trust, the interview panel will include four Governors, two of whom will be Public Governors, an independent external assessor and the Chief Executive, acting in an ex-officio capacity. The Chief Executive and the independent external assessor have no vote.

16.3 Terms of office of Non-Executive Directors

16.3.1 The Chairman and the Non-Executive Directors are to be appointed for a period of office in accordance with the terms and conditions of office decided by the Council of Governors at a general meeting. Non-Executive Directors will serve a three year period and will not normally exceed a maximum of three terms of office except in exceptional circumstances.

16.3.2 Any terms beyond two terms (six years) should be subject to annual endorsement of the continued appointment by the Council of Governors.

16.4 Board of Directors – roles and responsibilities

16.4.1 The general duty of the Board of Directors, and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

16.4.2 The business of the Trust shall be managed by the Board of Directors who, subject to this constitution, shall exercise all the powers of the Trust including:

16.4.2.1 to act as the critical decision making body of the Trust and to be accountable for the subsequent risks and liabilities that rest with this responsibility;

16.4.2.2 to set the strategic direction of the Trust within the overall limits detailed in the Licence by NHS Improvement;

16.4.2.3 to define its annual and longer-term objectives and agree plans to achieve them;

16.4.2.4 to oversee the delivery of its plan by monitoring performance against objectives and ensuring that corrective action is taken when necessary;

16.4.2.5 to ensure effective financial stewardship through value for money, financial control, financial planning and strategy;

16.4.2.6 to ensure high standards of corporate governance and personal behaviour are maintained in the conduct of business of the Trust;

16.4.2.7 to ensure appropriate mechanisms for the appointment, appraisal and remuneration of staff;

16.4.2.8 to endeavour to ensure effective dialogue between the Trust and the local community on its plans and performance and that these are responsive to the needs of the community; and,

16.4.2.9 to work collaboratively with the Council of Governors to ensure that each body understands their respective roles and responsibilities and develop practical ways of engaging and interacting with each other.

16.4.3 A third party dealing in good faith with the Trust shall not be affected by any defect in the process by which Directors are appointed or any vacancy on the Board of Directors.

16.4.4 All Directors will adhere to the policies and procedures of the Trust and shall act in the best interests of the Trust at all times.

16.5 Appointment of the Vice Chairman and Senior Independent Director

16.5.1 For the purposes of enabling the proceedings of the Trust to be conducted in the absence of the Chairman, the Council of Governors will appoint by simple majority, following a recommendation from the Chairman, a Non-Executive Director to be Vice Chairman for such a period, not exceeding the remainder of their term as a Non-Executive Director of the Trust.

16.5.2 The Board of Directors, following a recommendation from the Chairman and in consultation with the Council of Governors, will appoint a Non-Executive Director to be Senior Independent Director for such a period, not exceeding the remainder of their term as a Non-Executive Director of the Trust.

16.6 Remuneration and Nominations Committees

16.6.1 The Remuneration and Nominations Committee of Non-Executive Directors shall decide the terms and conditions of office, including remuneration and allowances, of the Executive Directors (including the Chief Executive). The Director of Workforce and Organisational Development shall be the secretary to this Committee. The Chief Executive shall be in attendance at the request of the Committee. Neither the Director of Workforce and Organisational

Development nor the Chief Executive shall be present to the discussion of their own remuneration.

16.6.2 The Remuneration, Nominations and Conduct Committee of Governors shall recommend to the Council of Governors the terms and conditions of office, including remuneration and allowances, of the Non-Executive Directors, including the Chairman.

16.6.3 The remuneration for Directors is to be disclosed in the annual report.

16.7 Disqualification

16.7.1 A person may not become or continue as a Director of the Trust if:

16.7.1.1 they are not of good character;

16.7.1.2 they do not have the qualifications, competence, skills and experience which are intrinsic for the work for which they are to be appointed, or have been appointed;

16.7.1.3 they have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity or providing a service which, if provided in England, would be a regulated activity;

16.7.1.4 they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

16.1.7.5 they have made a composition or arrangement with, or granted a trust deed for, their creditors and have not been discharged in respect of it;

16.7.1.6 they are the subject of a bankruptcy restriction order or an interim bankruptcy restriction order or an order to like effect made in Scotland or Northern Ireland;

16.7.1.7 they are a person to whom a moratorium period under a debt relief order applied under Part VIIA (Debt Relief Order) of the Insolvency Act 1986;

16.7.1.8 they are included on the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

16.7.1.9 they are prohibited from holding the relevant office or position or from carrying on the regulated activity, by or under enactment;

16.7.1.10 they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

16.7.1.11 any amount properly owing to the Trust by them remains outstanding without good cause;

16.7.1.12 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

16.7.1.13 in the case of a Non-Executive Director, they are no longer a member of a public constituency;

16.7.1.14 they are a person whose tenure of office as a Chairman or as a member or Director of a health service body has been terminated on the grounds that their appointing is not in the interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

16.7.1.15 they have had their name removed by a direction under paragraph 10 of the National Health Service (Performers Lists) Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere) and have not subsequently had their name included on such a list;

16.7.1.16 they have within the preceding two years been dismissed, for reasons considered to be inappropriate by the Trust, from any paid employment with a health service body;

16.7.1.17 in the case of a Non-Executive Director they have without good reason failed to fulfil any training requirement established by the Board of Directors;

16.7.1.18 in the case of a Non-Executive Director they have failed to sign and deliver to the Company Secretary, a statement in the form required by the Board of Directors, confirming acceptance of the code of conduct for Directors.

16.8 Meetings of the Board of Directors

16.8.1 Meetings of the Board of Directors shall be open to members of the public unless the Board of Directors decides otherwise in relation to all or part of such meetings having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. The Chairman may exclude any member of the public and representatives of the press from any meeting or part of meeting of the Board of Directors if they are interfering with or preventing the proper conduct of the meeting.

16.8.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting and a copy of the draft minutes of the previous meeting to the Council of Governors.

16.8.3 The Board of Directors shall meet at the direction of the Chairman. Standing Orders govern the proceedings and business of meetings. The proceedings shall not however be invalidated by any vacancy of its membership, or defect in a Director's appointment.

16.9 Committees and delegation

16.9.1 The Board of Directors shall have a schedule of delegation. Any of the powers of the Board may be delegated, whether to a committee, group of Directors, or to an Executive Director, subject to the Board maintaining a list of powers reserved to itself.

16.9.2 The Board of Directors shall appoint an Audit Committee of Non-Executive Directors to monitor the exercise of the external auditor's functions and perform such monitoring, reviewing and other functions as the Board of Directors shall consider appropriate. The Audit Committee shall function pursuant to its terms of reference.

16.10 Conflicts of interest

16.10.1 The duties that a Director has by virtue of being a Director include in particular:

16.10.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust;

16.10.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

16.10.2 The duty referred to in sub-paragraph 16.10.1.1 of this constitution is not infringed if:

16.10.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

16.10.2.2 the matter has been authorised in accordance with this constitution.

16.10.3 The duty referred to in sub-paragraph 16.10.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

16.10.4 In sub-paragraph 16.10.1.2 of this constitution. "third party" means a person other than:

16.10.4.1 the Trust; or

16.10.4.2 a person acting on its behalf.

16.10.5 If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, which includes a relevant and material interest in a matter as defined in Annex E and at 16.10.10 below, the Director must declare the nature and extent of that interest to the other Directors and it shall be recorded at the earliest opportunity and before the next meeting of the Board of Directors in a register of interests. Further guidance is also available from the Trust's Conflicts of Interest Policy. The Director in question:

16.10.5.1 shall not be present except with the permission of the Board of Directors in any discussion of the matter; and,

16.10.5.1 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

16.10.5.3 It shall be a disciplinary offence on the part of a Director wilfully to fail to disclose any interest required to be disclosed under the preceding paragraph.

16.10.6 Any declaration required by this paragraph 16.10 must be made before the Trust enters into the transaction or arrangement.

16.10.7 If a declaration under this paragraph 16.10 proves to be, or becomes inaccurate or incomplete, a further declaration must be made.

16.10.8 This paragraph 16.10 of the constitution does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

16.10.9 A Director need not declare an interest:

16.10.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

16.10.9.1 If, or to the extent that, the Directors are already aware of it;

16.10.9.2 If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

16.10.9.2.1 By a meeting of the Board of Directors; or

16.10.9.2.2 By a committee of the Directors appointed for the purpose under this constitution.

16.10.10 A material interest in a matter, as defined in Annex E, is any interest held by a Director, their spouse or partner, or a member of immediate family, in any firm or company or business which in connection with the matter is trading with the Trust or is likely to be considered as a potential trading partner with the Trust. The exceptions which shall not be treated as material interests are as follows:

16.10.10.1 shares not exceeding 1% of the total shares in issue held in any company whose shares are listed on any public exchange; and,

16.10.10.2 an employment contract with an appointing organisation held by a Non-Executive Director.

16.11 Expenses

16.11.1 The Trust may pay travelling and other expenses to Executive Directors and Non-Executive Directors at such rates as it decides.

17 Roles and responsibilities of the Company Secretary of the Trust

17.1 The Trust shall have a Company Secretary. The Company Secretary shall not be a member of the Council of Governors or the Chief Executive or the Finance Director. The Company Secretary's functions shall include responsibility for:

17.1.1 acting as secretary to the Council of Governors and the Board of Directors and such committees as may from time to time be required by either the Board or Council;

17.1.2 summoning and attending all meetings of the Council of Governors and the Board of Directors and keeping the minutes of those meetings;

17.1.3 keeping the register of members and other registers required by this constitution to be kept;

17.1.4 publishing to members, in appropriate form, information about the Trust's affairs; and

17.1.5 preparing and sending to NHS Improvement, and any other statutory body, all returns which are required to be made.

18 Registers

18.1 The Trust is to have:

18.1.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

18.1.2 a register of the Council of Governors;

18.1.3 a register of interests of the Council of Governors;

18.1.4 a register of Directors; and

18.1.5 a register of interests of the Board of Directors.

18.2 The Foundation Trust Office shall remove from the register of members the name of any member who ceases to be entitled to be a member under the provisions of this constitution, and will add the name of anyone who applies to be and becomes a member.

18.3 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

18.4 So far as the registers are required to be made available:

18.4.1 they are to be available for inspection free of charge at all reasonable times; and

18.4.2 a person who requests a copy of, or extract from, the registers is to be provided with a copy or extract.

18.5 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

19 Public documents

19.1 The following documents of the Trust are to be available for inspection by members of the public at all reasonable times and shall be available on the Trust's website, in line with the Trust's Freedom of Information Policy:

19.1.1 a copy of the current constitution;

19.1.2 a copy of the latest annual accounts and of any report of the external auditor on them;

19.1.3 a copy of the report of any other external auditor of the Trust's affairs appointed by the Council of Governors;

19.1.4 a copy of the latest annual report;

19.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

19.2.1 a copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act;

19.2.2 a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act;

19.2.3 a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act;

19.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

19.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

19.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (NHS Improvement's decision), 65KB (Secretary of State's response to NHS Improvement's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

19.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

19.2.8 a copy of any final report published under section 65I (administrator's final report) of the 2006 Act;

19.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act; and,

19.2.10 a copy of any information published under section 65M (replacement of Trust special administration) of the 2006 Act.

19.3 Any person who requests a copy of, or extract from any of the above documents, is to be provided with a copy. If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

20 External auditor

20.1 The Trust is to have an external auditor and is to provide the auditor with every facility and all information which he may reasonably require for the purposes of his functions under Schedule 10 to the 2006 and paragraph 23 of Schedule 7 to the 2006 Act.

20.2 A person may only be appointed as the external auditor if he (or in the case of a firm of each of its members) is a member of one or more of the bodies referred to in paragraph 23 (4) of Schedule 7 to the 2006 Act.

20.3 The Council of Governors at a general meeting shall appoint or remove the Trust's external auditors.

20.4 The external auditor is to carry out his duties in accordance with Schedule 15 to the 2006 Act and in accordance with any directions given by NHS Improvement on standards, procedures and techniques to be adopted.

20.5 The Board of Directors shall nominate a list of external auditors to be considered for appointment by the Council of Governors and may resolve that external auditors be appointment to review any other aspect of the Trust's performance. Any such external auditors are to be appointed by the Council of Governors.

21 Accounts

21.1 The Trust must keep proper accounts and proper records in relation to the accounts.

21.2 NHS Improvement may, with the approval of the Secretary of State, give directions to the Trust as to the content and form of the accounts.

21.3 The accounts are to be audited by the Trust's external auditor.

21.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS Improvement may with the approval of the Secretary of State direct.

21.5 The annual accounts, any report of the external auditor on them, and the annual report are to be presented and considered at a Council of Governors meeting. The Trust may combine a meeting of the Council of Governors convened for the purposes of this paragraph with the Annual Members' Meeting.

21.6 The Trust shall lay a copy of the annual accounts, and any report of the external auditor on them, before Parliament and send copies of those documents to NHS Improvement within such period as NHS Improvement may direct.

22 Annual reports, forward plans and non-NHS work

22.1 The Trust is to prepare annual reports and send them to NHS Improvement.

22.2 The Trust shall give information as to its forward planning in respect of each financial year to NHS Improvement. The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors.

22.3 Each forward plan must include information about:

22.3.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and.

22.3.2 the income it expects to receive from doing so.

22.4 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 22.3.1, the Council of Governors must:

22.4.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions; and

22.4.2 notify the Directors of the Trust of its determination.

22.5 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

23 Presentation of the annual accounts and reports to the Governors and members

23.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors for consideration:

23.1.1 the annual accounts;

23.1.2 any report of the external auditor on them; and

23.1.3 the annual report.

23.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting with at least one member of the Board of Directors in attendance.

23.3 The Trust may combine a meeting with the Council of Governors convened for the purposes of sub-paragraph 23.1 with the Annual Members' Meeting.

24 Indemnity

24.1 The Council of Governors and the Board of Directors and officers of the Trust, acting honestly and in good faith, will be indemnified against personal liability incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust. The Trust may purchase and maintain insurance against this risk.

25 Execution of documents

25.1 The Trust is to have a seal, but this is not to be affixed except under the authority of the Board of Directors.

25.2 A document purporting to be duly executed under the Trust's seal, or to be signed on its behalf, is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed.

26 Dispute resolution procedures

26.1 Other than where specified in the constitution or the Standing Orders of the Council of Governors, questions of eligibility, procedure and administrative matters in relation to governorship or meetings of members or Governors shall be determined by the Company Secretary, with the right of appeal to a committee of the Council of Governors convened for the purpose of this, whose decision shall be final and binding except in the case of manifest error.

26.2 Other than where specified in the constitution or the Standing Orders for the Board of Directors, questions of procedure and administrative matters in relation to directorship or meetings of Directors shall be determined by the Company Secretary, with the right of appeal to the Board of Directors convened for the purpose of this, whose decision shall be final and binding except in the case of manifest error.

27 Amendment of the constitution

27.1 No amendment shall be made to this constitution unless:

27.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments; and,

27.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

27.2 Amendments made under paragraph 27.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a results of the amendment, not accord with schedule 7 of the 2006 Act.

27.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors, or otherwise with respect to the role that the Council of Governors has as part of the Trust:

27.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and,

27.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment.

27.4 If more than half of the members voting approve the amendment, the amendment continues to have effect, otherwise it ceases to have effect and the Trust must take such steps as are necessary as a result.

27.5 Amendments by the Trust of its constitution are to be notified to NHS Improvement. For the avoidance of doubt, NHS Improvement's functions do not include a power or duty to determine whether or not the constitution as a result of the amendments accords with Schedule 7 of the 2006 Act.

28 Mergers etc. and significant transactions

28.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

28.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

28.3 Significant transaction means a transaction which would not otherwise require the approval of the Council of Governors under paragraph 28.1 above which meets any one of the criteria below:

Assets:
The gross assets subject to the transaction are greater than 25% of the Trust's existing gross assets.

Income:
The income attributable to the assets or the contract associated with the transaction is greater than 25% of the Trust's overall income.

Consideration to total Trust capital

The gross capital of the company or business being acquired/divested, is greater than 25% of the total capital of the Trust following completion, or the effects on the total capital of the Trust resulting from a transaction.

28.4 For the purposes of this paragraph:

28.4.1 "gross assets" is the total of fixed assets and current assets;

28.4.2 "gross capital" is the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets; and

28.4.3 "total capital" is the taxpayers' equity.

28.5 Material transaction means:

28.4.1 If a transaction meets the criteria above, but the details are greater than 10% of the assets, income or total capital of the Trust, it is considered to be a material transaction. Material transactions do not require more than half of the Council of Governors to vote to approve entering into the transaction however, the Trust would undertake consultation with the Council of Governors prior to entering into a material transaction.

29 Head office and website

29.1 The Trust's head office is at:

29.1.1 Harrogate and District NHS Foundation Trust, Lancaster Park Road, Harrogate, HG2 7SX.

29.2 The Trust maintains a website, the current address of which is:

29.2.1 www.hdft.nhs.uk

29.3 The Trust will display its name on the outside of its head office and at every other place at which it carries on business, and on its business letters, notices, advertisements and other publications.

29.4 Changes to the address and website will require a change to the constitution and will need to be approved by the Board of Directors and Council of Governors.

Annex A

1 Area of the Trust

Eligibility to become a public member will be available to people living within the defined catchment area of the Trust. This includes residents from the following Local Authority electoral areas (as defined for the purposes of local government elections):

- Harrogate and surrounding villages
- Ripon and West District
- Knaresborough and East District
- Wetherby and Harewood
- Alwoodley
- Otley and Yeadon
- Adel and Wharfedale
- The Rest of North Yorkshire and York
- The Rest of England

Membership will remain valid whilst ever a person resides in the above catchment areas.

Public constituencies with minimum numbers as described in 7.2.2:

Public constituency area 1 – Harrogate and surrounding villages is defined by the following electoral wards of Harrogate District Council:

Killinghall, Ripley, Washburn and Harrogate (including: Stray, Hookstone, Rossett, Pannal, Harlow Moor, Saltergate, New Park, Low Harrogate, High Harrogate, Bilton, Woodfield, Granby and Starbeck).

Public constituency area 2 - Ripon and West District is defined by the following electoral wards of Harrogate District Council:

Pateley Bridge, Mashamshire, Kirkby Malzeard, Nidd Valley, Lower Nidderdale, Bishop Monkton, Wathvale and Ripon (including Spa, Minster and Moorside).

Public constituency area 3 – Knaresborough and East District is defined by the following electoral wards of Harrogate District Council:

Newby, Boroughbridge, Claro, Ouseburn, Ribston, Marston Moor, Spofforth with Lower Wharfedale and Knaresborough (including Scriven Park, East and King James).

Public constituency area 4 – Wetherby, and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley Wards are defined by the Wetherby and Harewood electoral Wards of Leeds City Council.

Public Constituency Area 5 – rest of North Yorkshire and York is defined as those areas not served by public constituency areas 1 – 3.

Public Constituency Area 6 – the rest of England is defined as those areas not served by public constituency areas 1 – 5.

2 Staff constituency as defined in 7.3.1, with minimum numbers as described in 7.3.7

The Nursing and Midwifery Staff Class;

The Medical Practitioners' Staff Class;

The Other Clinical Staff Class; and,

The Non-Clinical Staff Class.

Annex B

MODEL ELECTION RULES

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4. Returning officer
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10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
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The poll

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33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text message

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

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PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (NHS Improvement, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*NHS Improvement*" means the corporate body known as NHS Improvement as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the

purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance

with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared

elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:
  (i) to whom the ballot paper was addressed, and/or

  (ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet

that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter

with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot

be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the

packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"ballot document" means a ballot paper, internet voting record, telephone voting record or text voting record.

"continuing candidate" means any candidate not deemed to be elected, and not excluded,

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"mark" means a figure, an identifiable written word, or a mark such as "X",

"non-transferable vote" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"preference" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"quota" means the number calculated in accordance with rule STV46,

"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a

combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"stage of the count" means:

(a) the determination of the first preference vote of each candidate,

(b) the transfer of a surplus of a candidate deemed to be elected, or

(c) the exclusion of one or more candidates at any given time,

"transferable vote" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"transferred vote" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"transfer value" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules

and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of

all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled, the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot

documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one

continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that NHS Improvement has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHS Improvement under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's

election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to NHS Improvement for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to NHS Improvement by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. NHS Improvement will refer the application to the independent election arbitration panel appointed by NHS Improvement.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 NHS Improvement shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

Annex C

Form of Declaration

Harrogate and District NHS Foundation Trust
Lancaster Park Road
Harrogate
HG2 7SX

Date:

Dear Sirs

Election or Nomination to the Office of Governor

I **……** confirm that I am a member of the ***staff constituency/public constituency/have been nominated by a partner organisation*** *[delete as appropriate],* and that I:

- am not a Director of the NHS Foundation Trust, or a governor of another NHS Foundation Trust;
- am not a public member who shares the same household as a member of the Board of Directors of the NHS Foundation Trust;
- have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement(whether unlawful or not) in the course of carrying out regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity;
- have not been adjudged bankrupt or my estate has been sequestrated and (in either case) I have not been discharged;
- have not made a composition or arrangement with, or granted a trust deed for, creditors and have not been discharged in respect of it;
- have not within the preceding 5 years been convicted in the British Islands of any offence where a sentence of imprisonment (whether suspended or not) for a period of not less than 3 months (without the option of a fine) was imposed;
- have not within the preceding two years been dismissed from any paid employment with a health for reasons considered to be inappropriate by this Trust;
- am not a person whose tenure of office as the chairman or as a member or director of a health service body has been terminated on the grounds that my appointment was not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
- have not had my name removed by a direction under paragraph 10 of the National Health Service (Performers Lists) Regulations 2004 or Section 151 of the 2006 Act (or similar provisions elsewhere), and have not subsequently had my name included in such a list;
- am not able by reason of my health of properly performing tasks which are intrinsic to the office for which I am elected or appointed;
- have not had my name placed on a register of Schedule 1 offenders pursuant

to the Sex Offences Act 2003 and/ or the Children and Young Persons Act 1933 and the conviction is not spent under the Rehabilitation of Offenders Act 1974;

- am not a vexatious complainant of the NHS Foundation Trust, as defined by the Trust policy;
- am not a vexatious litigant of the NHS Foundation Trust, as defined by the Trust policy;
- am not a family relation or occupant of the same household of a person who is an existing Governor of the NHS Foundation Trust; and
- confirm any amount properly owing to the NHS Foundation Trust by me, if any, does not remain outstanding without good cause.

Yours faithfully

…….
SIGNATURE

…….
PRINTED NAME

…….
DATE

Annex D

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 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 Company Secretary specifying the business to be carried out. The Company Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request. 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 one third of Governors in post and 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 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~~ Lead Governor 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 Chai~~Lead Governorr of the Governors shall chair that element of the meeting. In these circumstances and in the absence of the ~~Deputy Chairman~~Lead Governor, 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 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 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. 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 attend any meeting 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 Remuneration, Nominations and Conduct Committee for the purpose of making recommendations to the Council of Governors for the appointment of the Chairman and Non-Executive Directors. In addition this committee will consider 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 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

Annex E

Pursuant to Section 20 of Schedule 7 of the 2006 Act, a register of Director's and Governors' interests must be kept by each NHS Foundation Trust.

1. Declaration of Interests By Directors and Governors

1.1. All existing Directors (including for the purposes of this document, Non-Executive Directors) and Governors should declare relevant and material interests. Any Directors or Governors appointed or elected subsequently should do so on appointment or election.

1.2. Interests which should be regarded as "relevant and material" and which, for the avoidance of doubt, should be included in the register, are:

(a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies).

(b) Ownership, part-ownership or directorship of private companies, business or consultancies likely or possibly seeking to do business with the NHS.

(c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

(d) A position of Authority in a charity or voluntary organisation in the field of health and social care.

(e) A position of Authority in a local council or Local Authority, for example, a Councillor.

(f) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.

(g) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

1.3. If Directors or Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chairman.

1.4. At the time the interests are declared, they should be recorded in the Board of Director minutes or Council of Governor minutes as appropriate. Any changes in interests should be officially declared at the next Board meeting or Council of Governors meeting as appropriate following the change occurring. It is the obligation of the Director or Governor to inform the Company Secretary of the Trust in writing within 7 days of becoming aware of the existence of a relevant or material interest. The Company Secretary will amend the register upon receipt within 3 working days.

1.5. During the course of a Board of Director meeting or Council of Governor meeting, if a conflict of interest is established, the Directors or Governors 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, the majority will resolve the issue with the Chairman having the casting vote.

1.6. There is no requirement for the interests of Directors' or Governors' spouses or partners to be declared.

2. Register of Interests

2.1. The details of Directors and Governors interests recorded in the register will be kept up to date by means of a monthly review of the register by the Company Secretary of the Trust, during which any changes of interests declared during the preceding month will be incorporated.

2.2. Subject to contrary regulations being passed, the register will be available for inspection by the public free of charge. The Chairman will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the register must be provided to members of the Trust free of charge and within a reasonable time period of the request.

Harrogate and District NHS Foundation Trust

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Date of Meeting:	27 November 2019	**Agenda item:**	8.1
Report to:	Board of Directors		
Title:	Constitution Review 2019 – Update		
Sponsoring Director:	Mrs Angela Schofield, Chairman		
Author(s):	Mr Andrew Forsyth, Interim Company Secretary		

Report Purpose:

Decision	✓	Discussion/ Consultation	✓	Assurance		Information	

Executive Summary:

At the meeting on 6 November 2019, the Council of Governors approved the following changes to the Trust Constitution:

- Article 11.7.1 of the Trust Constitution to delete the word 'elected' from the sentence 'The Council of Governors shall elect a Deputy Chairman from amongst the elected Governors.'
- Change the title 'Deputy Chair/Chairman of Governors' to 'Lead Governor' throughout the Constitution.
- The Trust Board approved the changes on 25 September 2019.
- The final, amended, version is presented for approval.

Related Trust Objectives

To deliver high quality care	✓	To work with partners to deliver integrated care:		To ensure clinical and financial sustainability:	✓

Key implications

Risk Assessment:	None identified.
Legal / regulatory:	The Constitution of the Trust, article 27.1.2, requires more than half of the members of the Board of Directors voting to approve amendments to the Constitution
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	The Constitution of Harrogate and District NHS Foundation Trust (a Public Benefit Corporation) dated 1 August 2018

Action Required by the Board of Directors:

The Board of Directors is recommended to:

- **approve** the amended Constitution in accordance with Article 27.1.1

You matter most

Amendments to the Trust Constitution

1. At the Council of Governors' meeting held on 7 August 2019, the Council of Governors approved a number of changes to the Constitution.

2. Under the Constitution the recommended changes can only be made if more than half of the members of the Council of Governors of the Trust voting approve the amendments (Article 27.1.1). This requirement was met at that meeting.

3. Also under the Constitution, following a vote by the Council of Governors to make amendments, the Trust Board of Directors must approve them, again with more than half of the members of the Board voting to approve them (Article 27.1.2). This requirement was met at the meeting of the Trust Board on 25 September 2019.

4. The required amendments have now been made to the Trust Constitution and the final, amended, version was laid before the Council of Governors for approval on 6 November 2019. The Council of Governors' approval was unanimous.

5. The amended Trust Constitution was approved by the Council of Governors and is laid before the Trust Board of Directors for approval. At least half of the Board members voting must approve the changes. If approved, a copy will be deposited with NHS Improvement.

6. An amended copy of the Constitution, showing the changes, is attached.

NHS
Harrogate and District
NHS Foundation Trust

Date of Meeting:	30 October 2019	**Agenda item:**	C8.2
Report to:	Board of Directors		
Title:	Review of Treasury Management Policy		
Sponsoring Director:	Jonathan Coulter, Finance Director & Deputy Chief Exec		
Author(s):	Neil Outhwaite, Finance Analyst		

Report Purpose:

Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓

Executive Summary:

- The Trust's Treasury Management Policy has been reviewed by the Audit Committee (September 2019).
- The Audit Committee approved the policy and recommended approval by the Board.

Related Trust Objectives

To deliver high quality care		**To work with partners to deliver integrated care:**		**To ensure clinical and financial sustainability:**	

Key implications

Risk Assessment:	NHS Foundation Trusts are required to manage their affairs in a way that ensures they remain 'going concerns' and have access to sufficient cash and other liquid assets to meet their financial obligations. A key element of this is having an effective policy for Treasury Management.
Legal / regulatory:	NHS Improvement requirement.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	HDFT Treasury Management Policy V15 2019

Action Required by the Board of Directors:

The Board of Directors is recommended to:

- **approve** the attached Treasury Management Policy.

DRAFT

Harrogate and District NHS
NHS Foundation Trust

TREASURY MANAGEMENT POLICY

Version	Date	Purpose of Issue/Description of Change	Review Date
1-10 11 12 13 14 15	Jun 05 – Sep 14 Sept 2015 Sept 2016 Aug 2017 Aug 2018 Aug 2019	Initial Issue and 12 monthly review of Policy 12 month review of Policy 12 month review of Policy 12 month review of Policy 12 month review of Policy 12 month review of Policy	Jun 06 – Aug 15 August 2016 August 2017 July 2018 July 2019 August 2020
Status		Open	
Publication Scheme		Document Library>>Policies	
FOI Classification		Release without reference to author	
Function/Activity		Treasury Management	
Record Type		Policy	
Project Name		**N/A**	
Key Words		Treasury, Management, Policy, Finance	
Standard		**N/A**	
Scope / Location		Trust-wide	
Author		Head of Financial Accounts	**Date 30 August 2019**
Approval and/or Ratification Body		Board of Directors Board of Directors Board of Directors Board of Directors Board of Directors	May 05 – Jan 15 Oct 2015 Sep 2016 Aug 2017 Sep 2018

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1 INTRODUCTION

NHS Foundation Trusts are required to manage their affairs in a way that ensures they remain 'going concerns' and have access to sufficient cash and other liquid assets to meet their financial obligations. A key element of this is having an effective policy for Treasury Management.

Treasury Management includes the management of:

- Cash flow (monitoring and forecasting).
- Working capital management.
- Banking.
- Money and capital market transactions.
- Optimising returns through investment.
- Reducing financial transaction and borrowing costs.
- Minimising financial and corporate risk.

Donated funds are regulated by the Standing Financial Instructions and other guidelines relating to Charitable Funds and decisions on investments are made by the Trust's Charitable Funds Committee.

2 AIMS AND OBJECTIVES

The Treasury Management Policy aims and objectives are:

- To apply and develop professional standards and disciplines to the Treasury management function.
- To identify, manage, reduce and eliminate where possible, financial risk arising from operational and treasury management activities.
- To support the delivery of the Trust's objectives by ensuring short and long term availability of liquidity.
- To minimise costs by borrowing on flexible and competitively priced terms.
- To manage HDFT's liabilities and investment assets prudently ensuring commitments can be met as they fall due.

3 KEY RESPONSIBILITIES AND CONTROLS

The Chief Executive is the Accountable Officer for the Trust and is charged, with the Board, in ensuring probity in the use of public money. Responsibility for the day to day management of the Trust's financial systems rests with the Finance Director.

The Finance Director is responsible for the following:

- Ensuring that controls and processes are sufficient to meet the aims and objectives of the Treasury Management policy.
- Making recommendations to the Trust Board for a system of delegated authority limits and implementing and reviewing those limits on a regular basis.

- Establishing strict limitations on the types of investments for deposits of surplus cash and the circumstances in which they may be used.
- Managing daylight exposure (a limit set by a bank on its foreign-exchange dealings in a given currency with a particular counterparty) in the use of agreed counter-party limits.
- Ensuring that all moneys due from maturing or sold assets are received on time by the Trust.

4 INVESTMENTS

Cash investment decisions will be aimed at ensuring security, safeguarding liquidity and maximising income to support the financial aims of the Trust.

The Trust will only invest cash in organisations or financial institutions that offer the maximum security for the investment, in line with NHS Improvement's definition of a 'safe harbour' investment. The types of organisations that can provide this are:

- UK Government Departments and Agencies (excluding those contracted out to the private sector).
- Local Authorities.
- Banks, Building Societies and any similar institutions granted permission to trade by the FSA particularly those that are unlikely to fail).
- Approved Money Market Funds.
- Open ended investments such as unit trusts or bond funds where all elements of the investment meet NHS Improvement's safe harbour criteria.
- Revenue repurchase transactions where collateral is securities backed by the UK Government and the counterparty is a permitted institution under the NHS Improvement's definition.
- Wholly owned subsidiary companies.

5 APPROVED INVESTMENT INSTITUTIONS

The Department of Health changed the methodology for calculating Public Dividend Capital (PDC) dividends from 2013 onwards, by excluding cash from the calculation based on average daily cleared balances as opposed to opening and closing cash balance. This will have the effect of increasing the amount of PDC dividend paid annually. As the UK bank base rate is currently 0.75% and that returns from short term investment is very low, the cost of the extra PDC dividends far outweighs the benefit earned from the short term investment.

For example, on £5m there is a 3.5% saving on PDC dividend which totals £175,000 pa. Any investment made at the present time within this policy, and whilst the UK bank base rate is 0.75%, are unlikely to yield 3.5%. Therefore, the Trust does not intend to place any investment until UK bank base rate rises to 3.5% or above. At that time, the Audit Committee will consider the Investment Policy again. It is likely that some financial institutions, whilst meeting the current definitions outlined in section 4 of this policy, would be excluded because of individual credit ratings or other information.

The Trust will keep all of its cash with the Government Banking Service (GBS), the National Loan Fund (NLF) and Harrogate Healthcare Facilities Management Ltd (HHFM Ltd) until such time where base rate goes above 3.5%.

6 LIMIT PER COUNTERPARTY

GBS	Unlimited
NLF	Unlimited
HHFM Ltd	Unlimited

7 MAXIMUM INVESTMENT PERIOD

With the exception of equity held in HHFM Ltd the maximum period of 12 months will be permitted for investments. For investments with a fixed period of up to 6 months Finance Director approval is required. Board of Director approval is required for investments with a fixed period between 6 and 12 months.

8 DELEGATION OF RESPONSIBILITY FOR BORROWING

Post implementation of the Risk Assessment Framework the Trust no longer has a Prudential Borrowing Limit set annually by NHS Improvement. The Board will authorise the strategic use of all borrowing in advance; whilst delegating day-to-day responsibility for all borrowing to the Chairman and Chief Executive collectively.

One of any of the Non-Executive Directors can deputise for the Chairman. The Finance Director can deputise for the Chief Executive.

In order to carry out these duties, the Chairman and Chief Executive will request from the Finance Director as required reports on borrowing, including:-

- Performance monitoring.
- Review of borrowing requirements, funding plans and interest rate strategy.

The information included in the above reports will form part of the Trust's annual business planning process and the output of which will be approved by the Board of Directors.

9 AUDIT COMMITTEE

The Audit Committee is responsible for:

- Ensuring that public money is safeguarded and properly accounted for.
- Ensuring that the Trust's investment and borrowing strategy retains an appropriate risk profile.
- Ensuring that proper safeguards are in place for the security of the Trust's funds by agreeing the list of permitted institutions, setting investment limits for each institution and agreeing permitted investment types.

- Performing an annual review of this Policy and recommending approval to the Board of Directors.

10 APPENDICES

Appendix 1: Consultation Summary

10.1 Appendix 1: Consultation Summary

	List Groups and or Individuals Consulted
Those listed opposite have been consulted and comments/actions incorporated as required. The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval.	Finance Director/Deputy Chief Executive
	Deputy Finance Director
	Audit Committee

Harrogate and District NHS Foundation Trust

BOARD OF DIRECTORS SCHEDULE

Wednesday 27 November 2019

Venue: Boardroom, Trust Headquarters, Harrogate District Hospital

Patient Story	• **09.00am – 09.20am** • **Matron Gott and Mrs Jackson (tbc)**
Board meeting held in public	• **9.20am – 12.30pm** • **Covering strategic, performance, assurance and governance issues** • **Break between 11.00am and 11.15am**
Lunch	• **12.30pm – 1.00pm**
Board meeting held in private	• **1.00pm – 2.15pm** • **To discuss and consider confidential items**
Board to Council	• **2.30pm – 4.15pm**

You matter most

GLOSSARY OF ABBREVIATIONS

A

A&E	*Accident and Emergency*
AfC / A4C	*Agenda for Change*
AHPs	*Allied Health Professionals*
AIC	*Aligned Incentive Contract*
AMM	*Annual Members' Meeting*
AMU	*Acute Medical Unit*
AQP	*Any Qualified Provider*

B

BAF	*Board Assurance Framework*
BME	*Black and Minority Ethnic*
BoD	*Board of Directors*

C

CATT	*Clinical Assessment, Triage and Treatment Ward*
C.Diff	*Clostridium difficile*
CCCC	*Children's and County Wide Community Care Directorate*
CCG	*Clinical Commissioning Group*
CCU	*Coronary Care Unit*
CE / CEO	*Chief Executive Officer*
CEA	*Clinical Excellence Awards*
CEPOD	*Confidential Enquiry into Perioperative Death*
CIP	*Cost Improvement Plan*
CLAS	*Children Looked After and Safeguarding Reviews*
CoG	*Council of Governors*
COO	*Chief Operating Officer*
CORM	*Complaints and Risk Management*
CQC	*Care Quality Commission*
CQUIN	*Commissioning for Quality and Innovation*
CRR	*Corporate Risk Register*
CSW	*Care Support Worker*
CT	*Computerised Tomography*
CT DR	*Core trainee doctor*

D

Datix	*National Software Programme for Risk Management*
DBS	*Disclosure and Barring Service*
DNA	*Did not attend*
DoH	*Department of Health*
DoLS	*Deprivation of Liberty Safeguards*
Dr Foster	*Provides health information and NHS performance data to the public*
DToC	*Delayed Transfer of Care*

E

E&D	*Equality and Diversity*
eNEWS	*National Early Warning Score*
ENT	*Ear, Nose and Throat*
ERCP	*Endoscopic Retrograde Cholangiopancreatography*
ESR	*Electronic Staff Record*
EWTD	*European Working Time Directive*

F

FFT	*Friends and Family Test*
FC	*Finance Committee*
FIMS	*Full Inventory Management System*
FOI	*Freedom of Information*
FT	*NHS Foundation Trusts*
FY DR	*Foundation Year doctor*

G

GIRFT	Get it right first time
GPOOH	GP Out of Hours
GWG MD&C	Governor Working Group – Membership Development and Communications
GWG V&E	Governor Working Group – Volunteering and Education

H

HaRD CCG	*Harrogate and Rural District Clinical Commissioning Group*
HaRCVS	*Harrogate and Ripon Centres for Voluntary Service*
HBC	*Harrogate Borough Council*
HDFT	*Harrogate and District NHS Foundation Trust*
HDU	*High Dependency Unit*
HEE	*Health Education England*
HFMA	*Healthcare Financial Management Association*
HHFM	*Harrogate Healthcare Facilities Management Ltd*
HIF	*Harrogate Integrated Facilities*
HR	*Human Resources*
HSE	*Health & Safety Executive*
HSMR	*Hospital Standardised Mortality Ratios*

I

ICU or ITU	*Intensive Care Unit or Intensive Therapy Unit*
IG	*Information Governance*
IBR	*Integrated Board Report*
IT or IM&T	*Information Technology or Information Management & Technology*

K

KPI	*Key Performance Indicator*
KSF	*Knowledge & Skills Framework*

L

LAS DR	*Locally acquired for service doctor*
LAT DR	*Locally acquired for training doctor*
LCFS	*Local Counter Fraud Specialist*
LMC	*Local Medical Council*
LNC	*Local Negotiating Committee*
LoS	*Length of Stay*
LPEG	*Learning from Patient Experience Group*
LSCB	*Local Safeguarding Children Board*
LTUC	*Long Term and Unscheduled Care Directorate*

M

MAPPA	*Multi-agency Public Protection Arrangements*
MARAC	*Multi Agency Risk Assessment Conference*
MASH	*Multi Agency Safeguarding Hub*
MDT	*Multi-Disciplinary Team*
Mortality rate	*The ratio of total deaths to total population in relation to area and time.*
MRI	*Magnetic Resonance Imaging*
MRSA	*Methicillin Resistant Staphylococcus Aureus*
MTI	*Medical Training Initiative*

N

NCEPOD	*NCEPOD (National Confidential Enquiry into Perioperative Death)*
NED	*Non-Executive Director*
NHSE	*National Health Service England*
NHSI	*NHS Improvement*
NHSR	*National Health Service Resolution*
NICE	*National Institute for Health & Clinical Excellence*
NMC	*Nursing and Midwifery Council*
NPSA	*National Patient Safety Agency*
NRLS	*The National Reporting and Learning System*
NVQ	*National Vocational Qualification*
NYCC	*North Yorkshire County Council*

O

OD	*Organisational Development*
ODG	*Operational Delivery Group*
OSCE	*The Objective Structured Clinical Examination*

P

PACS	*Picture Archiving and Communications System – the digital storage of x-rays*
PbR	*Payment by Results*
PEAT	*Patient Environment Action Team*

PET	*Patient Experience Team*
PET SCAN	*Position emission tomography scanning system*
PHSO	*Parliamentary and Health Service Ombudsman*
PMO	*Project Management Office*
PROM	*Patient Recorded Outcomes Measures*
PSC	*Planned and Surgical Care Directorate*
PST	*Patient Safety Thermometer*
PSV	*Patient Safety Visits*
PVG	*Patient Voice Group*

Q

QIA	*Quality Impact Assessment*
QIPP	*The Quality, Innovation, Productivity and Prevention Programme*
QPR	*Quarterly Performance Review*

R

RCA	*Route Cause Analysis*
RTT	*Referral to Treatment. The current RTT Target is 18 weeks.*

S

SALT	*Speech and Language Therapy*
SAS DR	*Speciality and associate specialist doctors*
SCBU	*Special Care Baby Unit*
SHMI	*Summary Hospital Mortality Indicator*
SI	*Serious Incident*
SID	*Senior Independent Director*
SIRI	*Serious Incidents Requiring Investigation*
SLA	*Service Level Agreement*
SMR	*Standardised Mortality rate – see Mortality Rate*
SMT	*Senior Management Team*
SpR	*Specialist Registrar – medical staff grade below consultant*
ST DR	*Specialist trainee doctors*
STEIS	*Strategic Executive Information System*
STP	*Sustainability and Transformation Plan*

T

TOR	*Terms of Reference*
TU	*Trade Union*
TUPE	*Transfer of Undertakings (Protection of Employment) Regulations 2006*

V

VC	*Vice Chairman*
VSM	*Vey Senior Manager*
VTE	*Venous Throboembolism*

W

WTE	*Whole Time Equivalent*
WY&H HCP	*West Yorkshire and Harrogate Health Care Partnership*
WYAAT	*West Yorkshire Association of Acute Trusts*

Y

YTD	*Year to Date*

Further information can be found at:
NHS Providers – Jargon Buster –
http://nhsproviders.org/programmes/governwell/information-and-guidance/jargon-buster