

The meeting of the Board of Directors held in public will take place on
Wednesday 25 July 2018
Boardroom, Harrogate District Hospital, HG2 7SX
Start: 9.00am Finish: 12.30pm

AGENDA			
Item No.	Item	Lead	Paper No.
9.00am – 9.20am			
Patient Story			
9.20am – 10.30am			
1.0	Welcome and Apologies for Absence <i>To receive any apologies for absence:</i>	Mrs A Schofield, Chairman	-
2.0	Declarations of Interest and Register of Interests <i>To declare any interests relevant to the agenda and to receive any changes to the register of interests</i>	Mrs A Schofield, Chairman	2.0
3.0	Minutes of the Board of Directors meeting held on 27 June 2018 <i>To review and approve the minutes</i>	Mrs A Schofield, Chairman	3.0
4.0	Review Action Log and Matters Arising <i>To provide updates on progress of actions</i>	Mrs A Schofield, Chairman	4.0
Overview by the Chairman		Mrs A Schofield, Chairman	-
5.0	Board Terms of Reference <i>To receive for comment and approval</i>	Mrs A Schofield, Chairman	5.0
5.1	Third Party Schedule Annual Update <i>To receive for comment and approval</i>	Mrs A Schofield, Chairman	5.1
5.2	Review of the Trust's Constitution and Standing Orders <i>To receive for comment and approval</i>	Mrs A Schofield, Chairman	5.2
5.3	Dispute Resolution Procedure for disputes between the Board of Directors and Council of Governors <i>To receive for comment and approval</i>	Mrs A Schofield, Chairman	5.3
5.4	Harrogate Healthcare Facilities Management – Accounting Reference Date <i>To receive for comment and approval</i>	Mrs A Schofield, Chairman	5.4

6.0	Report by the Chief Executive Including the Integrated Board Report <i>To receive the report for comment</i>	Dr R Tolcher, Chief Executive	6.0a 6.0b
7.0	Report by the Finance Director <i>To receive the report for comment</i>	Mr J Coulter, Deputy Chief Executive/ Finance Director	7.0
10.30am – 10.40am			
Break			
10.40am – 12.30pm			
8.0	Report from the Chief Operating Officer <i>To receive the report for comment</i>	Mr R Harrison, Chief Operating Officer	8.0
9.0	Report by the Director of Workforce and Organisational Development <i>To receive the report for comment</i>	Mr P Marshall, Director of Workforce & Organisational Development	9.0
10.0	Report from the Chief Nurse <i>To receive the report for comment</i>	Mrs J Foster, Chief Nurse	10.0
10.1	Annual Infection Prevention and Control Report <i>To receive the report for comment</i>	Dr J Childs, Director of Infection Prevention and Control	10.1
11.0	Report from the Medical Director <i>To receive the report for comment</i>	Dr D Scullion, Medical Director	11.0
11.1	Guardian of Safe Working Hours Quarterly Report <i>To receive the report for comment</i>	Dr D Scullion, Medical Director	11.1
11.2	Learning from Deaths Quarterly Update <i>To receive the report for comment</i>	Dr D Scullion, Medical Director	11.2
12.0	Oral Reports from Directorates 12.1 <i>Planned and Surgical Care</i> 12.2 <i>Children's and County Wide Community Care</i> 12.3 <i>Long Term and Unscheduled Care</i>	Dr K Johnson, Clinical Director Dr N Lyth, Clinical Director Mr A Alldred, Clinical Director	- - -
13.0	Committee Chair Reports 13.1 <i>To receive the reports from the Quality Committee meeting held 4 July 2018.</i>	Mrs L Webster, Quality Committee Chair	13.1
14.0	Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators <i>To receive an update on any matters of compliance</i>	Mrs A Schofield, Chairman	-
15.0	Any other relevant business <i>By permission of the Chairman</i>	Mrs A Schofield, Chairman	-
	Board Evaluation	Mrs A Schofield, Chairman	-
Confidential Motion – the Chairman to move: <i>Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.</i>			

BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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

The register is maintained by the Company Secretary and was last updated in July 2018.

Name	Position	Interests Declared
Mr Andrew Alldred	Clinical Director LTUC	None
Mr Jonathan Coulter	Deputy Chief Executive/ Finance Director	Director of Harrogate Healthcare Facilities Management Limited (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. Appointed Voluntary Member of the Strategy and Resources Committee of the Methodist Church 2. Charity Trustee of Acomb Methodist Church, York
Dr Kat Johnson	Clinical Director PSC	None
Dr Natalie Lyth	Clinical Director CCCC	None
Mr Phillip Marshall	Director of Workforce and Organisational Development	1. Member of the Local Education and Training Board (LETB) for the North. 2. Harrogate Ambassador on behalf of Harrogate Convention Centre
Ms Laura Robson	Non-Executive Director	None
Mrs Angela Schofield	Chairman	1. Volunteer with Supporting Older People (charity).
Dr David Scullion	Medical Director	1. Member of the Yorkshire Radiology Group

Mr Richard Stiff	Non-Executive Director	<ol style="list-style-type: none"> 1. Director of /50% owner Richard Stiff Consulting Limited 2. Director of NCER CIC 3. Director and Trustee of TCV (The Conservation Volunteers) 4. Governor of Selby College
Mrs Maureen Taylor	Non-Executive Director	None
Mr Christopher Thompson	Non-Executive Director	<ol style="list-style-type: none"> 1. Director of Harrogate Healthcare Facilities Management Limited (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust) 2. Director – Neville Holt Opera 3. Member – Council of the University of York 4. Chair – Audit Yorkshire Consortium
Dr Ros Tolcher	Chief Executive	<ol style="list-style-type: none"> 1. Specialist Adviser to the Care Quality Commission 2. Member of NHS Employers Policy Board (Vice Chair). 3. Harrogate Ambassador on behalf of Harrogate Convention Centre
Mr Ian Ward	Non-Executive Director	<ol style="list-style-type: none"> 1. Non-Executive Director of : <ul style="list-style-type: none"> • Charter Court Financial Services Limited, • Charter Court Financial Services Group Limited, • Exact Mortgage Experts Limited, • Broadlands Finance Limited • Charter Mortgages Limited. In respect of the five companies above, Mr Ward is Chairman of the Remuneration Committee and Chairman of the Nominations Committee. Also, for each of them, he is a member of the Board Risk and Audit Committees. 2. Non-Executive Director of Newcastle Building Society and a member of the Group Risk Committee. Also, he is Chairman of its subsidiary companies, Newcastle Systems Management Limited and Newcastle Financial Advisers Limited. 3. Member, Leeds Kirkgate Market Management Board
Mrs Lesley Webster	Non-Executive Director	None
Deputy Directors		
Dr David Earl	Deputy Medical Director	<ol style="list-style-type: none"> 1. Private anaesthetic work at BMI Duchy hospital
Dr Claire Hall	Deputy Medical Director	<ol style="list-style-type: none"> 1. Trustee, St Michael's Hospice Harrogate

Mrs Joanne Harrison	Deputy Director of W & OD	None
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	None
Mr Paul Nicholas	Deputy Director of Performance and Informatics	None

Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors' meeting held in public on
Wednesday 27 June 2018 at 9.00am in the Boardroom at Harrogate General Hospital

- Present:** 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
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
Dr Ros Tolcher, Chief Executive
Mrs Lesley Webster, Non-Executive Director
Mr Ian Ward, Non-Executive Director
- In attendance:** Mr Andrew Alldred, Clinical Director for Long Term and Unscheduled Care
Mrs Joanne Harrison, Deputy Director of Workforce and Organisational Development
James Hughes, R&D Manager (minute 19.0)
Dr Kat Johnson, Clinical Director, Planned and Surgical Care
Mr David Lavalette, Trust Lead on NCEPOD (minute 14.0)
Dr Alison Layton Associate Director for Research (minute 19.0)
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services
Maggie Peat, Lead Research Nurse (minute 19.0)
Mrs Katherine Roberts, Company Secretary (minutes)
Ms CT, Patient Story (minute 19.0)

1.0 Welcome and Apologies for Absence

- 1.1 Mrs Schofield noted there was one apology for absence from Mr Phillip Marshall (Director of Workforce and Organisational Development)
- 1.2 It was confirmed a quorum was present at the meeting.
- 1.3 Mrs Schofield welcomed one observer to the meeting; Mr Paul Widdowfield (Communications & Marketing Manager).

2.0 Declarations of Interest and Board Register of Interests

- 2.1 No declarations of interest were received. All Directors confirmed that they had no direct or indirect interest in any item on the agenda which they were required to disclose

to the meeting.

2.2 It was noted Mr Coulter and Mr Thompson were Directors of Harrogate Healthcare Facilities Management (HHFM). 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 HHFM.

3.0 Minutes of the meetings of the Board of Directors on 30 May 2018

The draft minutes of the meeting held on 30 May 2018 were approved with the following amendments:

- Mr Richard Stiff and Mr Ian Ward should be added to the list of members present at the meeting.
- References within minutes 9.4 and 9.5 to the GDPR should read General Data Protection Regulations.

APPROVED:

The Board of Directors approved the minutes of the meeting held on May 2018 as an accurate record of proceedings subject to two amendments.

4.0 Review of Action Log and Matters Arising

4.1 Completed actions were noted. In addition it was confirmed action 93 was complete.

4.2 Actions 84, 94 and 97; Mrs Foster explained a proposal for a new format for patient safety visits and directors inspections would be discussed by the Director Team on 28 June 2018. It was agreed Non-Executive Directors would also be consulted on the proposals.

4.3 Action 92; Mr Harrison confirmed a new method for reporting accident and emergency performance had been agreed. The target would show as green if performance was above 95%, amber if performance was between 90% - 95% and red if performance was below 90%. It was agreed this action was complete.

4.4 Action 99; Mr Harrison confirmed a separate GDPR privacy statement was being developed for children and young people.

4.5 There were no other matters arising.

APPROVED:

The Board of Directors noted completed actions and received an update on actions and agreed to close actions 92 and 93.

Overview by the Chairman

Mrs Schofield noted a number of items:

- The Trust's new endoscopy unit had opened.
- A new Natural Health School had been launched within the Sir Robert Ogden Centre. The school would support people to achieve complementary therapy qualifications

while gaining experience of working with patients with health needs. In the long term the school would also enable the Trust to support a larger number of patients to access complementary therapies.

- The Trust had welcomed a visit by NHS Improvement to review the organisation's financial governance. Mr Coulter confirmed a report was being drafted by NHS Improvement and would be received during July 2018. It was noted that initial verbal feedback had been positive and included some helpful suggestions; the review team had been very impressed by the Board's open discussions. Following a question from Mrs Robson, Mr Coulter confirmed that the visit was not regulatory action; the recommendations would therefore be for the Trust to consider and decide whether to accept. The findings could influence the Trust's well led self-assessment.
- Members of the Board had attended a strategy event on 21 June 2018.
- The Trust would commence delivery of 0-19 healthy child services in Sunderland and Gateshead from 1 July 2018.
- A 'Board to Board' meeting had been held with the Governing Body of Harrogate and Rural District Clinical Commissioning Group (CCG). The meeting had been very positive and it was agreed the boards should meet again in autumn 2018.
- The NHS would celebrate its 70th birthday on 5 July. The Trust would be handing out cake to staff and patients to celebrate.

Mrs Schofield confirmed the theme for the meeting would be system working and partnerships.

Dr Tolcher confirmed she had no additional urgent matters to report to the Board.

Following the Board to Board meeting with the CCG, Mrs Robson suggested Non-Executive Directors could attend and observe meetings of the CCG's Governing Body on a rota basis.

ACTION: Mrs Roberts to circulate the dates of forthcoming CCG Governing Body Meetings.

5.0 Board governance documents for approval:

5.1 Mrs Schofield explained four documents had been circulated to Directors in advance of the meeting. These were updated Board of Directors terms of reference, a revised code of conduct for the Board, a summary of the division of responsibility between the Chairman and the Chief Executive and finally a summary of future Board dates for 2018.

5.2 Mrs Schofield confirmed Mrs Roberts had completed an annual review of the Board of Directors' terms of reference. It was noted that in advance of the meeting Mr Coulter had made some helpful suggestions regarding an additional reference to the Board's responsibilities in relation to Harrogate Healthcare Facilities Management. In addition it was proposed that reference to the Board's role as Corporate Trustee should be relocated to the 'governance' section of the terms of reference.

5.3 ACTION: Mrs Roberts to update the terms of reference and present to the Board for approval in July 2018.

5.4 Mrs Webster noted that the amendment to section 1.1 of the terms of reference which required all members of a committee to be members of the Board, this would

necessitate a change to the Quality Committee's terms of reference. Mrs Webster expressed her concern about losing input from current members of the committee who were not a director.

5.5 ACTION: Mrs Roberts and Mrs Webster to agree an appropriate resolution, and amend the Quality Committee terms of reference accordingly.

5.6 Mrs Roberts confirmed the code of conduct for the Board was based on the model recommended for NHS Foundation Trusts by NHS Providers. Following a question from Dr Johnson it was confirmed the code of conduct must be signed by every individual who regularly attended meetings of the Board, this included the Clinical Directors.

5.7 ACTION: Mr Marshall to consider whether Operational Directors should complete the Fit and Proper Person Test.

5.8 The statement of the division of responsibility between the Chairman and the Chief Executive was agreed.

5.9 The future schedule of meeting dates for the Board of Directors and the Finance Committee was approved.

5.10 Mr Coulter noted that subject to the receipt of feedback from NHS Improvement the Board may need to consider further how the new cycle of Board and Finance Committee meetings would operate most effectively.

APPROVED:

The Board of Directors:

- **Considered and approved the updated Board Code of Conduct.**
- **Considered and approved the statement of the division of responsibility between the Chairman and the Chief Executive**
- **Approved the schedule of future Board and Finance Committee dates.**

6.0 Report by the Chief Executive (excluding finance matters)

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

6.2 It was confirmed finance and operational performance had improved during May 2018. The year to date deficit was £2.4m, the same the position at the end of month one. There had therefore been an improvement to the run rate in month, but the Trust remained adverse of the 2018/19 operational plan.

6.3 The Trust achieved the A&E 4 hour standard with performance of 95.3%. However achievement of the 14 day maximum wait for symptomatic breast patients remained an issue. Dr Tolcher reported that referral to treatment (RTT) targets continued to improve but remained below the 92% standard.

6.4 There had been no changes to scores on the Board Assurance Framework. Corporate Risk 14 (failure of financial deficit and impact on service delivery due to failure to deliver the trust annual plan by having excess expenditure or a shortfall in income) had seen a reduced risk score from 16 to 12. In addition Corporate Risk 24 (risk to patient safety quality, experience, reputation, and staff wellbeing due to reduced capacity in the Community Care Teams) had reduced to 12.

6.5 Dr Tolcher reported a growing system wide understanding of the need to plan for the foreseeable pressures of the winter period and the resulting increased costs to the NHS. It was essential that the Trust had the necessary capacity and resources to keep patients safe. There was an ongoing constructive dialogue with the CCG.

6.6 Dr Tolcher confirmed that activity to date had been more than 1% higher than the profile agreed by the Trust and CCG within the Aligned Incentive Contract for 2018/19. As a result this had triggered further work with the CCG to discuss realigning resources from elective to non elective care.

6.7 Mrs Schofield noted the Finance Committee had received an update presentation about the new Aligned Incentive Contract model and suggested this would be helpful for the whole Board.

6.8 ACTION: Mrs Roberts to schedule an update for the Board about the new Aligned Incentive Contract at the August Board Workshop.

6.9 Mr Thompson highlighted the Health and Social Care Select Committee report into the development of new integrated ways of planning and delivering local health and care services. He noted their recommendation for areas to adopt a principle of subsidiarity, and queried where decisions should be made, local or regional level. Dr Tolcher said she had been encouraged by the report which supported the approach adopted within West Yorkshire and Harrogate. Despite initial criticism, from the early stages of development West Yorkshire and Harrogate had sought to allow decision making to be as close to patients as possible.

6.10 The Board noted the potential emergence of a super-resistant bacterium within two patients at the Trust. Dr Tolcher confirmed there had been no evidence of patient to patient transfer, however there was nervousness that this could be another significant national problem similar to MRSA. Dr Scullion added the Trust had escalated the issue for attention at regional and national level.

6.11 Mrs Webster referred to the letter from NHS Improvement regarding reducing Long Stays in Hospital. She sought clarity about whether there would be penalties if the Trust failed to achieve the prescribed target by December 2018. Dr Tolcher confirmed that to date there had been no indication that penalties would be imposed, but it was expected the target would be monitored closely. Mr Harrison said the Trust welcomed the target as it supported a whole system focus on reducing the number of long term and 'super stranded' patients. He explained a new metric had been included within the Integrated Board Report, which demonstrated a performance trajectory against the December target.

6.12 Following a question from Mrs Taylor it was confirmed the letter had also been issued to the CCG.

6.13 Mr Coulter noted performance against the target would improve patient experience and would be beneficial to the Trust financially. Dr Scullion expressed concern that actions to support a reduction in the number of long term patients were heavily biased towards the Trust; he queried what other organisations within the district would do to support an improvement. Mr Harrison said he was more confident than he had been in previous years, but this did not guarantee the target would be achieved. He highlighted the lack of out of hospital beds within Harrogate district. Dr Tolcher said the system was

doing everything possible to achieve commitment and confidence, but the proof of success of the new system approach would be when operational challenges were faced during winter 2018/19. She emphasised that reducing long stays in hospital would be better for patients, as well as saving NHS resources.

APPROVED:

The Board of Directors:

- **Noted progress on risks recorded in the BAF and Corporate Risk Register and confirmed that progress reflected the current risk appetite; and**
- **Endorsed use of the Trust's seal and agreement of a licence as detailed in the report.**

7.0 Finance Report including Financial Recovery Plan and CIP update

7.1 The report had been circulated in advance of the meeting and was taken as read. Mr Coulter noted the report had been considered by the Finance Committee.

7.2 Mr Coulter reported that the Trust had broken-even during May 2018 and not achieved the £400k surplus planned. Pressures during the month included ward and theatre staffing costs plus corporate CIP pressures.

7.3 Mr Coulter drew attention to page six of his report which provided additional information about workforce. The year to date variance for theatres and day surgery was 20% above plan and 26% above plan for ward staffing. He explained that the increased demand for healthcare support workers had been driven by an apparent increase in the need for enhanced care for patients. A number of additional controls on staffing had been introduced. In addition staff had been reminded that the ward staffing establishment had been set at a level which would enable wards to appropriately manage the acuity of patients. It was therefore expected that there would be a reduction in the number of additional staffing shifts requested. It was noted NHS Improvement would undertake a staffing review in late July 2018.

7.4 Mr Coulter explained that the Trust had exceeded the agency ceiling during May 2018. This was a key marker in determining the Trust's 'use of resources' rating and therefore despite a target of two, the use of resources rating had declined to three.

7.5 It was confirmed that 87% of CIP schemes were in place against the £10.7m target. Mr Stiff queried whether reporting on CIPs included adjustment following a risk analysis. Mr Coulter confirmed that it did, CIP reporting included risk adjusted values. Mr Harrison added that the programme management team and finance teams worked together to risk assess all CIP schemes and consider the level of assurance available that schemes would deliver forecast savings.

7.6 A key risk for the Trust remained funding for the national agenda for change pay award. Confirmation regarding the national funding position had not been received. The Trust had prepared internal calculations to forecast the cost of the new pay award. There was no further action the Trust could take at this stage.

7.7 The Trust's cash position at the end of May 2018 was £2.6m and therefore remained significantly pressured; this had been discussed in detail by the Finance Committee. Mr Coulter confirmed that he had sought further guidance about the distressed cash regime in order to understand the application processes should the Trust

need to seek this support. The Trust was owed £1.1m from the Treasury (sustainability and transformation funding), £1.5m by the CCG, £700k by NHS E and £400k relating to VAT.

7.8 Following a question from Mrs Robson it was confirmed the shift incentive scheme had been a local initiative introduced by the Trust to help cover staffing gaps. Now that staffing gaps had reduced, it had been decided shift incentive schemes should be removed.

7.9 Mrs Robson queried whether the corporate directorate should have a higher CIP target than other directorates. Mr Coulter said he did not believe the Board should distinguish between front line and support staff, all provided valuable services. Dr Tolcher agreed it was an important question for the Board, she noted the Trust had access to detailed benchmarking from WYAAT which provided an opportunity for further analysis of how the Trust compared to peers.

7.10 Mr Ward commented that the Trust's financial position was better than the external plan, and this was positive, however the plan included more challenging targets later in the year. Mr Coulter explained 2018/19 budgets had been set based on the internal plan.

7.11 Mrs Webster highlighted detail included within the report about the Trust's top five commissioners and queried why there had been variation within the percentages of funding provided. Mr Coulter confirmed it was usual for this to fluctuate, and in month for NHS England had related to high cost drugs.

7.12 Dr Johnson provided an update on plans to mitigate forecast reduced activity during August 2018. Dr Tolcher emphasised the importance of ensuring theatres were fully utilised during this period.

7.13 ACTION: Dr Johnson to provide a further update to the Senior Management Team regarding plans to mitigate forecast reduced activity during August 2018.

7.14 Mrs Taylor explained the Finance Committee had considered the May 2018 financial position in detail. Activity was generally on or above plan, however levels of expenditure were above plan. In particular spending on ward staffing had been above forecast, it was therefore pleasing that extra controls on ward staffing had been implemented. She welcomed the forthcoming NHS Improvement review of staffing, it would support the Board to assess whether the Trust was an outlier when compared with other Trusts.

7.15 Mrs Harrison noted staff concern that wards were understaffed and could not deliver the care they want to provide. There was therefore an important exercise to 'win hearts and minds'. Mrs Foster said she agreed, and noted that some feedback from patients also suggested there were too few staff on wards.

APPROVED:

The Board of Directors noted the contents of the report and the actions that were being progressed to achieve the financial plan.

8.0 Integrated Board Report

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

8.2 Following a question from Mr Thompson, Dr Scullion and Mrs Foster confirmed work continued to improve the Datix incident reporting system. Following the failure of an initial plan, the Trust was working with Datix to engaged expert support to redesign the system.

8.3 Mrs Schofield queried whether previous year trends could be added to a number of measures within the report.

8.4 ACTION: Mr Harrison to consider whether previous year trends could be added to a number of measures within the Integrated Board Report.

APPROVED:

The Board of Directors received and noted the Integrated Board Report.

9.0 Report from the Chief Operating Officer

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

9.2 Mr Harrison highlighted ongoing work to develop the options to support the care of hyper acute strokes for the population of Harrogate. The Trust was working on a set of options for review. It was expected a detailed options appraisal would be prepared during July 2018, with public communications from August 2018, and the agreed plan to be enacted by late 2018. Mr Harrison explained there were two models being considered, the first would involve patients being diverted to their nearest unit (eg Leeds or York), the second model would mean patients would continue to be seen in Harrogate with the support of Leeds or York clinicians via telemedicine and the transfer of patients to another Trust when required. It was noted Dr Tolcher and Mr Harrison would discuss the proposals with the Overview and Scrutiny Committee in late July 2018.

9.3 Mr Thompson queried whether the Trust would see a change to the skill set of HDFT staff. Mr Harrison confirmed there would be a focus on stroke care rehabilitation (post 72 hours of a stroke), rather than on the first part of the stroke care pathway. Mr Harrison emphasised that the Trust needed to be part of a wider clinical network which facilitated peer support and enabled review and support when staff were on leave.

APPROVED:

The Board of Directors received and noted the contents of the report.

10.0 Supported Discharge Service Business Case

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

10.2 Mr Harrison gave a short presentation to support presentation of Supported Discharge Service (SDS) business case to the Board.

10.3 He explained the business case should be considered in the context of the Aligned Incentive Contract which the Trust had agreed with the CCG for 2018/19. He updated the Board about the key features of the Aligned Incentive Contract.

10.4 Mr Harrison explained that planning for winter 2018/19 had commenced, and it was calculated winter costs would be comparable to 2017/18 at £1.6m. It was important that

the Trust and the CCG planned for these foreseeable costs. In order to meet these costs the Trust and the CCG had agreed to realign £1.5m funding for planned care to underwrite the costs of winter. As a result the Trust would need to do things differently and potentially stop doing some things.

10.5 Mr Harrison explained that in addition to identifying the necessary funding there was also a question about whether the Trust had sufficient beds to meet the increased demand anticipated during winter because during winter 2017/18 Harrogate Hospital had reached its bed capacity. It was noted that using escalation beds provided a sub optimal environment for patients and there were significant challenges in obtaining the staff necessary to support these additional beds.

10.6 Mr Harrison explained that SDS had been trialled in spring 2018. The service had demonstrated achievement of reducing bed occupancy by 4.5 beds. The business case proposed that by investing further in SDS the Trust could reduce occupancy by 15 beds. Furthermore the service was beneficial for patients and the wider health system.

10.7 Analysis had demonstrated that if the Trust did nothing the bed base would be exceeded during 2018/19. If the SDS was expanded the Trust would need to open a small number of escalation beds on occasion, but for the majority of the year the hospital would operate within the bed base.

10.8 Mr Harrison explained that option four (SDS plus) was recommended to the Board for approval, this model would also help to reduce elective cancellations and support A&E performance.

10.9 Mr Coulter noted that that there would be a financial risk for the Trust if SDS did not achieve the forecast switch in elective care. In addition there was an operational risk including the impact on waiting times and differential standards for patients. It would be important to maintain theatre capacity with activity funded by commissioners other than Harrogate and Rural District CCG.

10.10 Mr Harrison noted that there was an inherent risk to the Trust in adopting the new SDS model. The service had been trialled at a particular level, but it could not be guaranteed the level of bed reduction that would be achieved by SDS plus model.

10.11 Dr Tolcher concluded that the hypothesis proposed by the business case was introducing SDS would safely deliver a reduction in the number of established beds.

10.12 Following a question from Ms Robson, Mr Harrison confirmed that the SDS plus model would deliver an addition ten beds, meeting half of the NHS Improvement challenge.

10.13 Dr Scullion noted that clinicians may express concern about introducing differential waiting times for patients. Dr Johnson confirmed clinical teams might need to manage two waiting lists if other solutions did not emerge; she expressed concern about the Planned and Surgical Care Directorate's capacity to deliver this on top of other priorities. Mr Harrison noted additional support would be provided to directorate teams from CCG staff.

10.14 Dr Tolcher emphasised the importance of engaging clinicians in the process, and ensuring that they felt supported. It would take a longer period of time to reduce demand, there was therefore a need to increase control on planned care activity in-year. The Trust

had sufficient activity within existing waiting lists from CCGs outside Harrogate to maintain activity levels. She noted that a meeting was planned with Leeds CCG to discuss this further.

10.15 Mrs Taylor asked whether the CCG was supportive of the business case. Mr Coulter confirmed the business case and the wider implications had been discussed with executives at the CCG, and also with regulators. Mr Harrison noted the new format contract with the CCG, the Aligned Incentive Contract made funding SDS possible.

10.16 Following a question from Mrs Robson, Mr Harrison confirmed it was not anticipated that there would be a problem recruiting therapists needed to deliver the expanded SDS.

10.17 Mr Stiff sought assurance about care plan implementation. Mr Harrison explained North Yorkshire County Council had been involved in the pilot work. In addition the two organisations were seeking co-locate some adult social care teams at Harrogate Hospital.

10.18 Mrs Webster noted that the method of reporting the impact of SDS would be important. Mr Harrison confirmed mechanisms would be introduced to enable clear reporting. He also commented that the post investment review would need to be an iterative process.

10.19 All members of the Board confirmed their support and approval for the Supported Discharge Service Business Case and associated costs (£1,184,700).

APPROVED:

The Board of Directors approved the Supported Discharge Service Business Case and associated costs (£1,184,700).

11.0 Report by the Director of Workforce and Organisational Development

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

11.2 Mrs Harrison provided an update on the clinical workforce strategy, and noted the Trust's level of sickness absence had increase. Although she highlighted that the Trust continued to perform well against national and regional sickness absence trends.

APPROVED:

The Board of Directors noted items included within the report.

12.0 Report from the Chief Nurse

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

12.2 Mrs Foster highlighted the level of pressure ulcers, the quality of care provided by the Community Care Teams, the level of complaints and the NHS Improvement collaboration.

12.3 Mrs Foster confirmed that a new process had been implemented to increase controls on requests for temporary additional ward staffing, this included approval by the Chief Nurse, Chief Operating Officer or Director on call. The Matrons and Heads of Nursing had been involved in development of this process. Mrs Foster confirmed she had

written to all nursing staff to address concerns raised about the new approach to ward staffing. Mrs Foster explained that she was actively monitoring quality and safety indicators to ensure that the new process had not had a negative impact on the safety of care provided.

12.4 Mr Alldred agreed ward staff were anxious and he confirmed his directorate were working closely with wards and reviewing risk on a daily basis. Mrs Foster explained the Trust had a robust tool to identify those patients who required additional care needs; this was reviewed for each patient on a daily basis.

12.5 Mrs Schofield asked whether there had been a decline in requests for additional staffing. Mrs Foster said requests had continued, but had not all been approved.

12.6 Mrs Taylor highlighted section 1.8 of the report, and asked for further information about the number of 'hours owed' to the Trust decreasing. Mr Coulter reminded the Board this was a historic issue, Mrs Foster added that a recent review of rostering by internal audit had reached a finding of 'significant assurance'.

APPROVED:

The Board of Directors:

- **Confirmed they were assured by the work being undertaken to improve nurse recruitment and retention and the governance process for assuring safe staffing levels;**
- **Noted actions being undertaken to maintain safe staffing levels, quality of care and reduce cost.**
- **Noted the action being taken regarding Director Inspections and Patient Safety Visits.**
- **Noted the increase in community and hospital acquired pressure ulcers in month.**
- **Noted the work around falls reduction.**
- **Confirmed they were assured about the monitoring of care provided by the Community Care Teams.**
- **Noted the number of complaints in 2017/18.**
- **Noted HDFT is participating in NHS Improvement Collaborative to improve Enhanced Care.**

13.0 Report from the Medical Director

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

13.2 Dr Scullion highlighted three recent consultant appointments, the Trust's strong performance on organ donation and JAG accreditation for the new endoscopy unit.

APPROVED:

The Board of Directors received and noted the report.

14.0 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Annual Report

14.1 Mr Lavalette joined the meeting.

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

14.3 Mr Lavalette confirmed that he continued to engage with clinicians and offer support where possible, however he acknowledged there were a few pockets of limited engagement.

14.4 For some of the historic reports the agenda had moved on significantly, and Mr Lavalette proposed that the Trust should re-evaluate whether the agreed action plans remained the correct course of action. This would necessitate further discussion with the leads on these historic reports, for example where there had been no progress for a number of years. Dr Scullion confirmed that he agreed there was a need to reflect and re-evaluate.

14.5 Mr Webster expressed concern on behalf of the Quality Committee about the volume of external reports and action plans the Trust was required to respond to. Dr Tolcher noted that action plans developed following external reports or clinical audits should be seen as part of the day job, they provided assurance that necessary actions were being implemented.

14.6 ACTION: the Quality Committee to consider further whether the Trust could adopted a different approach to the management of action plans following external reports and clinical audits.

14.7 The Board expressed their thanks to Mr Lavalette for his leadership of this very important area of work.

APPROVED:

The Board of Directors received and noted the report.

15.0 Oral Reports from Directorates

15.1 Planned and Surgical Care Directorate

15.1.1 Dr Johnson provided a verbal update from the Planned and Surgical Care Directorate. She noted:

- The impact of the level of vacancies within theatres (29%), and the associated implications of relying on agency staff. This was not an easy issue for the Trust to resolve. Mrs Foster highlighted the positive impact following implementation of the Trust's theatre strategy; however Dr Johnson said she felt progress had stalled.
- There were pressures within medical staffing, especially middle grades. Mr Ward queried whether exit questionnaire were being utilised. Dr Johnson confirmed they were.

15.2 Children's and County Wide Community Services Directorate

15.2.1 Dr Lyth provided a verbal update from the Children's and County Wide Community Services Directorate. She noted:

- There was cautious optimism about recruiting middle grades, the new approach to CESR rotation was proving attractive to candidates.
- Ofsted would be undertaking an inspection of services within North Yorkshire County Council.

15.3 Long Term and Unscheduled Care Directorate

15.3.1 Mr Alldred provided a verbal update from the Long Term and Unscheduled Care Directorate. He noted:

- Work continued with Hambleton, Richmondshire and Whitby CCG to reconfigure GP Out of Hours Services. He noted a risk to resilience of the service during the summer 2018 period.
- There had been a meeting with senior staff within pathology services to explore options for collaborative working with other trusts. This had been a very positive meeting.

16.0 Committee Chair Reports

Mrs Schofield welcomed reports from the Board's committees.

16.1 Report from the Quality Committee meeting held on 6 June 2018

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

APPROVED:

The Board of Directors:

- **Noted Quality Committee action to gain assurance re Quality Impact Assessments;**
- **Noted Quality Committee's request for SMT to reconsider scope of new Quality Priority related to *Improving the Clinical Model of Care for Acute Services*;**
- **Noted Quality Committee challenge about the Trust's capacity to support external audits.**

16.2 Finance Committee meeting held on 14 June 2018

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

16.2.2 ACTION: At future meetings, the Finance Committee report to be taken alongside the Finance Report.

APPROVED:

The Board of Directors received and noted the report.

17.0 Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators

17.1 It was confirmed there were no items to be reported.

18.0 Any other relevant business not included on the agenda

There was no other business.

19.0 Research Update and Patient Story

Dr Alison Layton, Mr James Hughes and Ms Maggie Peat joined the meeting alongside Ms CT a patient.

The Board welcomed Ms CT and thanked her for sharing her patient story.

Ms CT explained that she had taken part in the 'Prepare ABC trial' which sought to address the outcomes for patients having colorectal surgery following a diagnosis of bowel cancer. Prior to her surgery she attended an exercise counselling session where she was given resistance bands, a pedometer and an exercise diary. She was to come in to hospital to see the physio up to 3 times a week. Following her surgery she continued to attend hospital based exercise sessions. Ms CT said that she had found involvement in the trial a thoroughly positive experience and she had enjoyed the gym sessions. She felt she was fitter than before her surgery, in particular her stamina had improved. She also highlighted the valuable moral support provided to her by the physio team throughout her treatment.

Mrs Webster commented it was interesting that the moral support offered had been as important as taking part in the exercise programme. Ms CT agreed the combination of both the moral support and exercise had been valuable and had encouraged her to take actions to help herself.

Mrs Taylor queried how Ms CT's recovery had compared to other patients. Ms Peat confirmed results of the research were not yet known.

The Board received an update presentation from the research and development team which demonstrated how research supported the quality of care provided to patients. The team emphasised that the landscape in which NHS research was conducted was changing. There was an increasing emphasis on public health and disease prevalence. The team outlined their commitment to authentic patient and public involvement and engagement in research.

The team continued to look for opportunities for the Trust to participate in research activity; the increasing importance of digital technology was highlighted. It was expected that the next generation of clinical researchers would increasingly be drawn from allied health professionals rather than necessarily doctors.

The Trust had out performed the target on research activity; the organisation was 'punching above its weight'.

The Board expressed their thanks to the team and Ms CT for attending the meeting.

20.0 Board Evaluation

Dr Tolcher said she thought the SDS presentation had been good. Mrs Webster noted it would have been helpful for the Non Executives to have had an opportunity to meet and consider the business case in advance of the meeting, in order to ask for questions and clarification.

21.0 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 12.40pm.

HDFT Board of Directors Actions Schedule

Action Log

June 2018

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 measures within the integrated board report regarding patient experience in adult and children community services.	Mr Harrison, Chief Operating Officer / Mr Alldred, Clinical Director LTUC / Dr Lyth, Clinical Director CCWC	September 2018	
84	January 2018	Following review of patient safety visit format proposals to be the Board for comment and consideration.	Mrs J Foster, Chief Nurse	May 2018 (see action 97 below)	Complete Included within Chief Nurse Report
94	April 2018 (minute 12.3)	Mrs Foster to schedule director inspections for 2018/19	Mrs J Foster, Chief Nurse	June 2018 (see action 97 below)	Complete Included within Chief Nurse Report
95	May 2018 (minute 4.3)	Schedule visit for Board to the new endoscopy unit.	Mr Jonathan Coulter, Deputy Chief Executive / Mrs Roberts, Company Secretary	August 2018	Complete Two dates offered to Directors to visit the new unit.
97	May 2018 (minute 5.9)	Mrs Foster to progress a programme of Director Inspections and Patient Safety Visits.	Mrs J Foster, Chief Nurse	July 2018	Complete Included within Chief Nurse Report
98	May 2018 (minute 6.5)	Mrs Roberts to schedule a board workshop regarding capital funding	Mrs Katherine Roberts, Company Secretary	July 2018	Complete Added to Board work plan
99	May 2018 (minute 9.5)	Mr Harrison to consider developing a separate GDPR privacy statement for children and young people.	Mr Harrison, Chief Operating Officer	July 2018	
100	June 2018 (minute 4.0)	Mrs Roberts to circulate the dates of forthcoming CCG Governing Body Meetings	Mrs Katherine Roberts, Company Secretary	July 2018	Complete Dates circulated to Non

			Secretary		Executive Directors
101	June 2018 (minute 5.3)	Mrs Roberts to update the terms of reference and present to the Board for approval in July 2018.	Mrs Katherine Roberts, Company Secretary	July 2018	Complete Agenda item 5.0
102	June 2018 (minute 5.5)	Mrs Roberts and Mrs Webster to agree an appropriate resolution, and amend the Quality Committee terms of reference accordingly.	Mrs Webster, Non Executive Director & Mrs Katherine Roberts, Company Secretary	October 2018	
103	June 2018 (minute 5.7)	Mr Marshall to consider whether Operational Directors should complete the Fit and Proper Person Test.	Mr Marshall, Director of Workforce & OD	July 2018	Verbal update at meeting
104	June 2018 (minute 6.9)	Mrs Roberts to schedule an update for the Board about the new Aligned Incentive Contract at the August Board Workshop.	Mrs Katherine Roberts, Company Secretary	August 2018	
105	June 2018 (minute 7.15)	Dr Johnson to provide a further update to the Senior Management Team regarding plans to mitigate forecast reduced activity during August 2018.	Dr Johnson, Clinical Director	July 2018	Verbal update at meeting
106	June 2018 (minute 8.4)	Mr Harrison to consider whether previous year trends could be added to a number of measures within the Integrated Board Report.	Mr Harrison, Chief Operating Officer	October 2018	
107	June 2018 (minute 14.6)	Quality Committee to consider further whether the Trust could adopted a different approach to the management of action plans following external reports and clinical audits.	Mrs Webster, Non Executive Director	October 2018	
108	June 2018 (minute 16.2.3)	At future meetings, the Finance Committee report to be taken alongside the Finance Report.	Mrs Katherine Roberts, Company Secretary	October 2018	

Date of Meeting:	25 July 2018	Agenda item:	5.0							
Report to:	Board of Directors									
Title:	Board of Directors Terms of Reference									
Sponsoring Director:	Mrs Angela Schofield, Chairman Dr Ros Tolcher, Chief Executive									
Author(s):	Mrs Katherine Roberts, Company Secretary									
Report Purpose:	<table border="1"> <tr> <td>Decision</td> <td>✓</td> <td>Discussion/ Consultation</td> <td></td> <td>Assurance</td> <td></td> <td>Information</td> </tr> </table>			Decision	✓	Discussion/ Consultation		Assurance		Information
Decision	✓	Discussion/ Consultation		Assurance		Information				
Executive Summary:	<ul style="list-style-type: none"> The Board of Directors has Terms of Reference which require annual review. The Board considered the draft Terms of Reference in June 2018 and agreed two further amendments should be made. These further amendments are highlighted in yellow and relate to: <ul style="list-style-type: none"> a) the Board's responsibilities as the sole shareholder in Harrogate Healthcare Facilities Management; b) relocation of the Board's responsibilities as corporate trustee from the 'finance' to 'governance' section. 									
Related Trust Objectives										
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓	
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 Board is required to have terms of reference to support the legal requirements outlined in the constitution and standing orders.									
Resource:	None identified.									
Impact Assessment:	Not applicable.									
Conflicts of Interest:	None identified.									
Reference documents:	Board Terms of Reference									
Assurance:	Not applicable, this matter is reserved to the Board.									
Action Required by the Board of Directors:										
It is recommended that the Board considers and approves the updated Terms of Reference.										

Harrogate and District NHS Foundation Trust Board of Directors

Terms of Reference

1. Introduction

- 1.1 Harrogate and District NHS Foundation Trust is led by a unitary Board of Directors which is responsible for exercising all the powers of the Trust on its behalf, however may delegate any of those powers to a committee of the Board (comprised of a group of Board Directors) or to an Executive Director.
- 1.2 The Board of Directors, in its capacity as Corporate Trustee, takes responsibility for the overall management and governance of charitable funds and related fund-raising activity.

2. Membership

- 2.1 The members of the Board shall comprise of the Chairman of the Trust, Chief Executive Officer, all the Non-Executive Directors and Executive Directors who hold voting rights on the Board.
- 2.2 In accordance with the Trust's Constitution, the composition of the Board of Directors shall be:
 - The Chairman of the Trust;
 - A minimum of six Non-Executive Directors (including the Vice-Chairman and the Senior Independent Director);
 - The Chief Executive Officer (also the Chief Accountable Officer);
 - Executive Directors to include as a minimum:
 - Director of Finance (also the Chief Accounting Officer);
 - Medical Director (who shall be a registered medical or dental practitioner);
 - Chief Nurse (who shall be a registered nurse or midwife);
 - Two other Executive Directors (currently the Chief Operating Officer and Director of Workforce and Organisational Development);
- 2.3 The Deputy Chief Executive shall be selected from the Executive Director cohort (currently the Director of Finance).
- 2.4 Only members of the Board shall be entitled to attend meetings.
- 2.5 Clinical Directors from the three operational directorates and the Company Secretary, will have a standing invitation to meetings of the Board of Directors, but will not hold voting rights. Other officers of the Trust and other individuals may be invited to attend meetings or part of meetings as required by the Board or as the Chairman sees fit.
- 2.6 The record of attendance of members will be included in the annual report of the Board.

3.0 Voting

- 3.1 Members of the Board will each be entitled to cast a single vote on matters before it. In the case of an equality of votes the Chairman of the meeting is to have a casting vote. Provisions to deal with conflicts of interest are provided for in the Trust's Constitution and Standing Orders.

4. Quorum

- 4.1 No business shall be transacted at meetings of the Board unless a minimum of five voting Directors are present including at least two Executive Directors and three Non-Executive Directors. A duly convened meeting of the Board at which a quorum is present shall be competent to exercise all or any of the authorities, powers or discretions vested in or exercisable by the Trust.
- 4.2 An officer representing an Executive Director at meetings of the Board of Directors may not count towards the quorum, unless formal 'acting up' status has been previously agreed.

5. Frequency

- 5.1 The Board shall meet formally in public on a bi-monthly basis, at a location that it may determine. There will be a minimum of ten-six meetings per year. Additional meetings of the Board may be called in accordance with the Trust's Standing Orders.

6.0 Notice of Meetings

- 6.1 Meetings of the Board shall be called by the Company Secretary in accordance with the annual schedule of business or as determined by the Chairman.
- 6.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Board and any other person required to attend no later than five working days before the date of the meeting. Supporting papers shall be sent to members and other attendees as appropriate at the same time.
- 6.3 The agenda of the Board of Director meetings held in public shall be forwarded to the Council of Governors prior to the meeting, and ensure that agenda, minutes and supporting papers are available publicly on the Trust's website.
- 6.4 After each Board meeting held in public, the Board of Directors must make available a copy of the minutes to the Council of Governors.

7.0 Meetings Administration

- 7.1 The Company Secretary shall minute the proceedings and resolutions of all meetings of the Board, including the names of those present and in attendance.

7.2 The Company Secretary shall keep a separate record of all points of action arising from the meetings and all issues carried forward.

7.3 The Chairman shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and determine how they should be managed in accordance with the Constitution and Standing Orders. ~~‡The Company Secretary shall minute the~~ conflicts of interest, and approach chosen to manage them accordingly.

8.0 Main Responsibilities

8.1 The general duty of the Board and of each Director individually, is to promote the success of the organisation so as to maximise the benefits for the members of the organisation as a whole, and for the public.

8.2 As a unitary body, the Board of Directors is responsible for decision making associated with:

8.2.1 The strategic direction of the Trust;

8.2.2 The provision of high quality and safe healthcare services, healthcare delivery, education, training and research;

8.2.3 Overall performance of the Trust in relation to standards set by regulatory bodies.

8.2.4 Ensuring the Trust exercises the its functions effectively, efficiently and economically;

8.2.5 Ensuring effective arrangements are in place for governance and risk management;

8.2.6 Ensuring compliance with the Trust's Provider Licence and associated legislation, regulation and best practice.

9.0 Duties

9.1 Leadership and Culture. The Board:

9.1.1 Ensures there is a clear vision for the Trust that people understand and that is being implemented within a framework of prudent and effective controls.

9.1.2 Sets values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values.

9.1.3 Promotes and patient-centred culture of openness, transparency and candour, has an intolerance of poor standards and fosters a culture which puts patients first.

9.1.4 Ensures the Trust is an excellent employer through the development of a workforce strategy and its appropriate implementation and operation.

9.1.5 Ensures that Directors, Governors, staff and volunteers adhere to any codes of conduct adopted or introduced.

9.1.6 Implements an effective Board and Committee structure and clear lines of accountability and reporting throughout the organisation.

- 9.1.7 Ensures there are appropriately constituted appointment arrangements for senior appointments such as Executive Directors and consultant medical staff.

9.2 Strategy. The Board:

- 9.2.1 Sets and maintains the Trust's strategic vision, aims and objectives ensuring that the necessary financial, physical and human resources are in place for it to meet its objectives.
- 9.2.2 Develops and maintains an annual business plan, with due regard to the views of the Council of Governors, and ensures its delivery, as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.
- 9.2.3 Ensures that national policies and strategies are effectively addressed and implemented within the Trust.

9.3 Quality and Performance. The Board:

- 9.3.1 Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience are achieved.
- 9.3.2 Monitors and reviews management performance to ensure the Trust's objectives are met and identifies opportunities for improving the delivery of high quality services.
- 9.3.3 Monitors feedback relating to the experiences of people who use the services and the processes for proactive engagement.
- 9.3.4 Ensures it engages with all stakeholders, including patients and staff on quality issues and that issues are escalated appropriately and dealt with when required.
- 9.3.5 Ensures the proper management of resources and that responsibility for financial and quality of service are achieved.
- 9.3.6 Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required.
- 9.3.7 Ensures that there are sound processes and mechanisms in place to ensure effective patient and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services.
- 9.1.8 Ensures that there are sound processes in place to ensure compliance with, and awareness of equality and diversity standards.

9.1.9 Ensures that the organisation promotes clinical research.

9.4 Finance. The Board:

- 9.4.1 Ensures the Trust operates effectively, efficiently and economically to ensure the continuing financial viability of the organisation.

9.4.2 Ensures the proper management of resources and that financial and quality of service responsibilities are fulfilled, and ensures the achievement of targets and requirements of stakeholders within available resources.

9.4.3 Ensure effective financial stewardship through effective value for money, financial control and financial planning and strategy.

~~9.4.4 Acts as Corporate Trustee for the Trust's fundraising charity, charity number 1050008 (registered as the Harrogate and District NHS Foundation Trust Charitable Fund) and in respect of all existing charitable funds.~~

~~9.4.5 Oversee the effective management of the Harrogate Hospital & Community Charity and ensure good governance and legal compliance in the areas of public fund-raising and donor data protection.~~

9.5 Governance. The Board:

9.5.1 Ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to contemporary guidance, and appropriate codes of conduct, accountability, openness and transparency.

9.5.2 Ensures that the Trust complies with the requirements of its Licence, governance and assurance obligations in the delivery of safe clinically effective services.

9.5.3 Ensures that the Trust has comprehensive governance arrangements in place guarantee the resources vested in the Trust are appropriately managed and deployed.

9.5.4 Ensures that all required returns and disclosures are made to the Regulators.

9.5.5 Formulates, implements and reviews Standing Orders and Standing Financial Instructions as a means of regulating the conduct and transactions of the Trust's business.

9.5.6 Agrees the schedules of matters reserved for decision by the Board of Directors.

9.5.7 Ensures proper management of, and compliance, with, statutory requirements of the Trust and, ensures the statutory duties of the Trust are effectively discharged.

9.5.8 Establishes appeals panels as required by employment policies particularly to address appeals against dismissal and final stage grievance hearings.

~~9.5.9 Acts as Corporate Trustee for the Trust's fundraising charity, charity number 1050008 (registered as the Harrogate and District NHS Foundation Trust Charitable Fund) and in respect of all existing charitable funds.~~

~~9.5.10 Oversee the effective management of the Harrogate Hospital & Community Charity and ensure good governance and legal compliance in the areas of public fund-raising and donor data protection.~~

~~9.5.11 Maintains oversight of the Trust's wholly owned subsidiary company (Harrogate Healthcare Facilities Management).~~

9.6 Risk Management and Internal Control. The Board:

- 9.6.1 Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives.
- 9.6.2 Ensures that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements in line with the requirements of the Provider Licence.
- 9.6.3 Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities.
- 9.7 **Communication and Engagement.** The Board:
 - 9.7.1 Ensures relationships are maintained with the Trust's stakeholders, regulators, public, governors, staff and patients, such that the Trust can discharge its wider duties.
 - 9.7.2 Meets its engagement obligations in respect of the Council of Governors and members and ensures that the Governors are equipped with the skills and knowledge they require to undertake their role.
 - 9.7.3 Works in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, effective, accessible and well governed services.
 - 9.7.4 Ensures the effective dissemination of information on organisational strategies and plans, providing a mechanism for feedback.
 - 9.7.5 Holds an annual meeting of its members which is open to the public.
 - 9.7.6 Approves and publishes the Trust's Annual Report and Accounts, Quality Accounts and other statutory submissions.
- 10.0 **Committees**
 - 10.1 The Board is responsible for establishing and maintaining committees with delegated responsibilities and powers as prescribed by the Trust's Standing Orders and/or by the Board of Directors.
- 11. **Review and revision**
 - 11.1 These Terms of Reference will be reviewed annually and the Board will conduct an annual review of its effectiveness and shall act on its findings.

~~Approved~~ DRAFT July 2018 ~~May 2017~~

Date of Meeting:	25 July 2018	Agenda item:	5.1								
Report to:	Board of Directors										
Title:	Third Party Schedule Annual Update										
Sponsoring Director:	Dr Ros Tolcher, Chief Executive										
Author(s):	Mrs Katherine Roberts, Company Secretary										
Report Purpose:	<table border="1"> <tr> <td>Decision</td> <td>✓</td> <td>Discussion/ Consultation</td> <td></td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td></td> </tr> </table>			Decision	✓	Discussion/ Consultation		Assurance	✓	Information	
Decision	✓	Discussion/ Consultation		Assurance	✓	Information					
Executive Summary:	<ul style="list-style-type: none"> The Board of Directors is required, under the Foundation Trust Code of Governance, to maintain a schedule of the specific third party bodies in relation to which the NHS Foundation Trust has a duty to cooperate. The Board reviews and approves the Trust's third party schedule on an annual basis. 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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 Trust is required, under the Foundation Trust Code of Governance, to maintain a schedule of the specific third party bodies in relation to which the NHS Foundation Trust has a duty to cooperate.										
Resource:	None identified.										
Impact Assessment:	Not applicable.										
Conflicts of Interest:	None identified.										
Reference documents:	NHS Foundation Trust Code of Governance: https://www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance										
Assurance:	Not applicable, this matter is reserved to the Board of Directors.										
Action Required by the Board of Directors:											
It is recommended that the Board receives and approves the updated Third Party Schedule.											

Third parties with roles in relation to Harrogate and District NHS Foundation Trust July 2018

This list is indicative and not exhaustive and is split into third parties with a specific remit in healthcare and those with a more general remit. The list may change from time to time and will be added to as appropriate.

1. Third parties with statutory enforcement powers with a statutory remit specific to healthcare:

- NHS Improvement
- Care Quality Commission

Bodies with statutory enforcement powers include, for example, the Health and Safety Executive, the regulators of health professionals such as the General Medical Council, the Nursing and Midwifery Council and the fire authorities. NHS Improvement does not reasonably expect to be involved in the resolution of issues covered by such bodies, except where persistent failures may indicate fundamental governance failings and a breach of the Licence.

2. Regulators of individual health professionals:-

- General Chiropractic Council
- General Dental Council
- General Medical Council
- General Optical Council
- General Osteopathic Council
- General Pharmaceutical Council
- Health and Care Professions Council
- Nursing and Midwifery Council

Each of the above regulators has the power to demand the release of information where it relates to a hearing about the fitness to practise of health professionals. Some regulators may also have powers in relation to the accreditation of courses, education or training for health professionals wishing to register.

3. Third parties with a general statutory remit:

- Charities Commission
- Environment Agency
- Equality and Human Rights Commission
- Fire Authorities
- Health and Safety Executive
- HM Coroner
- Human Tissue Authority
- Information Commissioner's Office
- Public Accounts Committee
- Secretary of State for Health (may issue directions applicable to Foundation Trusts)

4. Third parties with statutory role but no enforcement powers with a remit specific to healthcare:

Bodies that have a statutory role in setting or monitoring compliance with health care standards, but no direct enforcement powers, include commissioners and scrutiny of health committees.

- Commissioners
- Health and Wellbeing Boards
- Public Health England
- NHS Blood and Transplant
- Parliamentary and Health Service Ombudsman
- NHS Digital
- Overview and scrutiny committees
- Healthwatch and Healthwatch England
- Local Authority Scrutiny of Health Committees

5. Third parties with a general remit:

- Ofsted
- National Audit Office

6. Third parties with no statutory role but a legitimate interest:

There are bodies with no statutory powers over NHS Foundation Trusts which may have a legitimate interest in their operations. NHS Improvement expects that NHS Foundation Trusts will generally cooperate with such bodies and a failure to cooperate may, under certain circumstances, constitute a breach of the governance licence condition and grounds for action.

These bodies include nationally recognised accreditation services, such as Clinical Pathology Accreditation (UK) Ltd, committees, working groups and forums advising the Department of Health on topics across health and social care such as the National Specialised Commissioning Group, some arm's length bodies such as the National Institute for Health and Clinical Excellence (NICE), and the medical Royal Colleges.

NHS Improvement expects such bodies to influence NHS Foundation Trusts through the advice they give and NHS Foundation Trusts to report to NHS Improvement any issues raised by such bodies that could indicate a breach of their governance condition. NHS Improvement will review any reports of non-cooperation, failure to take account of relevant advice or serious or persistent concerns from such third parties with the NHS Foundation Trust and make its own judgment on how to proceed. NHS Improvement may choose to intervene if it believes this to be necessary.

- Committees, working groups and forums advising Department of Health on topics across health and social care
- Confidential Enquiries

- Criminal Records Bureau
- Health Education England
- NHS Business Services Authority
- NHS Resolution
- Universities and Post Graduate Deaneries
- UK Accreditation Service
- Royal Colleges, including:-
 - Royal College of Anaesthetists
 - Royal College of Emergency Medicine
 - Royal College of General Practitioners
 - Royal College of Midwives
 - Royal College of Nursing
 - Royal College of Obstetricians and Gynaecologists
 - Royal College of Ophthalmologists
 - Royal College of Paediatrics and Child Health
 - Royal College of Pathologists
 - Royal College of Pharmaceutical Medicine
 - Royal College of Physicians
 - Royal College of Psychiatrists
 - Royal College of Radiologists
 - Royal College of Speech and Language Therapists
 - Royal College of Surgeons

Date of Meeting:	25 July 2018	Agenda item:	5.2								
Report to:	Board of Directors										
Title:	Review of the Constitution, Standing Orders and Scheme of Reservation and Delegation										
Sponsoring Director:	Mrs Angela Schofield, Chairman Dr Ros Tolcher, Chief Executive										
Author(s):	Mrs Katherine Roberts, Company Secretary										
Report Purpose:	<table><tr><td>Decision</td><td>✓</td><td>Discussion/ Consultation</td><td></td><td>Assurance</td><td></td><td>Information</td><td></td></tr></table>			Decision	✓	Discussion/ Consultation		Assurance		Information	
Decision	✓	Discussion/ Consultation		Assurance		Information					
Executive Summary:	<p>Constitution</p> <ul style="list-style-type: none">A review of the Constitution has been completed by the Constitution Review Working Group. This Group consists of the Chairman, Chief Executive, four Governors, a Non-Executive Director (Maureen Taylor) and the Company Secretary.The review highlighted a number of areas for recommended amendments to the Constitution. These are summarised in the table overleaf.In addition the Working Group considered a proposal to include a new category of staff governor specifically from the Children’s and County Wide Community Care Directorate, however it was determined that due to technical difficulties with the membership database it was not possible to enact this at the current time.In line with the Code of Governance, the Working Group considered in detail a procedure for the management of Governor conduct concerns, this will be presented to the Council of Governors for approval in August.Amendments to the Constitution require approval by both the Board of Directors and the Council of Governors. <p>Standing Orders and Scheme of Reservation and Delegation</p> <ul style="list-style-type: none">The Trust’s Standing Orders and its annex the Scheme of Reservation and Delegation require annual review.A comprehensive review has been completed by the Company Secretary and was shared with the Chairman, Executive Directors and the Chair of the Audit Committee for comment.The review highlighted a number of areas for recommended amendments to the Standing Orders. These are summarised in the table overleaf.										

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:	<p>The Constitution, Standing Orders and Scheme of Reservation and Delegation form the core elements of the Trust's legal framework.</p> <p>There will be resulting changes required to the Trust's Standing Financial Instructions; these will be actions presentation in September 2018.</p> <p>In addition the Board will need to approve terms of reference for the newly formed Remuneration and Nominations Committee; these will be presented in September 2018.</p> <p>Amendments to the Constitution require approval by both the Board of Directors and the Council of Governors.</p>				
Resource:	None identified.				
Impact Assessment:	Not applicable.				
Conflicts of Interest:	None identified.				
Reference documents:	NHS Foundation Trust Code of Governance				
Assurance:	<ul style="list-style-type: none">• Amendments to the Constitution have been considered in detail and agreed by the Constitution Review Working Group.• Amendments to the Standing Orders and Scheme of Reservation and Delegation have been considered by the Chair of the Audit Committee.				
Action Required by the Board of Directors:					
<p>It is recommended that the Board:</p> <ul style="list-style-type: none">• Agrees the proposed amendments to the Constitution and recommends them to the Council of Governors for approval on 1 August 2018.• Approves the revised Standing Orders.• Approves the revised and Scheme of Reservation and Delegation.					

Summary of proposed amendments to the Trust's Constitution July 2018

Area	Details	Section
Council of Governors	1) The Nominations Committee and the Remuneration Committee for the appointment of the Chairman / NEDs will be merged to form a single committee; the <i>Remuneration, Nominations and Conduct Committee</i> .	16.2
	2) The organisations which are invited to appoint Stakeholder Governors were reviewed. As a result it is proposed that;	11.2.3
	<ul style="list-style-type: none"> • Harrogate and Rural District LMC is removed from the constitution. This follows a prolonged period during which the LMC were unable to identify an individual to appoint as a Governor. • The description of the voluntary and community sector should be broadened beyond Harrogate and Ripon. This will allow flexibility in engaging a Governor, for example from the Trust's wider delivery footprint beyond Harrogate and Ripon. 	
	3) The quorum for Council of Governor meetings to be amended to one third, bringing it in line with other Foundation Trusts and reducing the risk that meetings will be inquorate.	Annex D - 2.1
	4) In accordance with the Code of Governance for Foundation Trusts, new provisions have been added to address in more detail the procedure for the removal of Governors. This will be accompanied by a new Procedure for the Management of Governor Conduct Concerns.	11.9
	5) Addition of the power for the Chairman to exclude people from meetings of the Council of Governors should they interfere with or prevent the conduct of a meeting.	
Board of Directors	1) Additional provisions have been added which formalise the process for appointment of the Trust's Vice Chairman and the Senior Independent Director.	16.5
	2) The Nominations Committee and the Remuneration Committee of the Non-Executive Directors will be merged to form a single committee; the <i>Remuneration and Nominations Committee</i> .	16.6
Membership	1) As a result of the General Data Protection Regulations the Constitution has been amended to clarify that staff must opt in to become Members of the Trust.	7.1.4



Miscellaneous	1) Additional references have been added to the Trust's Conflicts of Interest Policy (which replaced the Standards of Business Conduct Policy / Code).	11.12 & 16.10.5
	2) Out of date NHS terminology has been updated, for example the Health and Social Care Information Centre is now called NHS Digital.	5.3.1
	3) References to the 'Secretary' of the Trust have been updated to the 'Company Secretary'.	17.1
	4) Throughout the Constitution references to the 'trust' has been amended to the 'Trust'.	-
	5) A number of definitions which were missing have been added to the interpretations and definitions section.	1.3

Summary of proposed amendments to the Trust's Standing Orders

Section	Details	Reference
Standing Orders	<ul style="list-style-type: none"> • Addition of missing definitions to the Interpretation Section • Throughout document updated references to the <u>Chairman</u>. • Updated references to the new Remuneration and Nominations Committee. • Clarification members of the Board of Directors may participate in meetings by telephone, video or computer link. • Removal of the list of defined reports which will appear on every agenda to enable flexibility in agenda planning. • Quorum updated to match the Board's agreed Terms of Reference. • Clarification the Board will only delegated to a committee formed of Directors, or to individual Executive Directors. • Sections regarding management of conflicts of interest updated in accordance with recent guidance for NHS Trusts, and brought into line with the Constitution (e.g. reference to material rather than pecuniary interests). • Removal of references to Standards of Business Conduct; replaced with references to the Conflicts of Interest Policy. • Removal of Council of Governors Standing Orders, this was duplication with the Constitution. 	<p>1.</p> <p>-</p> <p>-</p> <p>3.2</p> <p>3.10</p> <p>3.36</p> <p>5.1</p> <p>6. – 7.</p> <p>8.</p> <p>Annex A</p>

Summary of proposed amendments to the Trust's Scheme of Reservation and Delegation

Section	Details
Scheme of Reservation and Delegation	<ul style="list-style-type: none"> • Minor amendments identified following a gap analysis of the Standing Orders adopted by other Foundation Trusts, including addition of "Clinical Standards and Patient Safety" section. • Clarification that the Trust Board would authorise any joint ventures and the establishment of subsidiary companies. • Clarification that the Board nominates the Vice Chairman of the Trust for ratification by the Council of Governors. • Clarification that the Board appoints the Senior Independent Director following consultation with the Council of Governors. • New title for the Remuneration and Nominations Committee. • Removal of reference to approving management policies because in practice this is not reserved to the Board. • Addition of the Board's role in approving the Trust's Annual Report, Quality Account and Annual Accounts. • Addition of the powers already agreed by the Board which are reserved to the Board in relation to Harrogate Healthcare Facilities Management Limited • Addition of powers reserved to the Board which are detailed in the Trust's Constitution. • Updated details of the powers delegated to the new Remuneration and Nominations Committee. • Additional section detailing powers delegated to the Charitable Funds Committee. • Additional section detailing powers delegated to the Quality Committee. • Additional section detailing powers delegated to the Finance Committee. • Duties of the Chief Executive updated in accordance with the current Accounting Officer Memorandum. • Updated section on the Board's Codes of Conduct and Accountability following updated guidance for Foundation Trusts.

**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 ~~28 TBC August~~ **February** 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;
" A ccounting O fficer"	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 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;
<u>"Chairman"</u>	<u>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;</u>
<u>"Company Secretary"</u>	<u>means the individual appointed to perform the duties of the Secretary to the trustTrust as defined in section 17 of this constitution;</u>
<u>"constitution"</u>	means this constitution and all annexes to it;
"Council of Governors"	means the Council of Governors as constituted in accordance with this constitution;
<u>"Deputy Chairman of</u>	<u>means the person appointed to preside over</u>

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 <u>Trust</u> 's licence granted by Monitor under the 2012 Act;
"Medical Practitioners' Staff Class"	means the staff class of the 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 <u>Trust</u> ;
"member"	means a member of the trust <u>Trust</u> ;
"the trust <u>Trust</u> "	means Harrogate and District NHS Foundation Trust;

“Public Governor” means a member of the Council of Governors elected by members of the public constituencies;

~~“Secretary” means the secretary of the trustTrust who could be known as the Company Secretary or any other person appointed to perform the duties of the Secretary;~~

~~“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 on the Trust~~ Trust’s Making Experiences Count Policy; website at <http://www.hdft.nhs.uk/about-us/statutory-information/>

~~“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 ~~trustTrust~~ is Harrogate and District NHS Foundation Trust (the ~~trustTrust~~).

3 Principal purpose

- 3.1 The principal purpose of the ~~trustTrust~~ is the provision of goods and services for the purposes of the health service in England.
- 3.2 The ~~trustTrust~~ 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~~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~~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~~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~~Trust for the purposes of the ~~trust~~Trust or for any purposes relating to the health service); and,

4.2.4 employ staff.

4.3 Any power of the ~~trust~~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~~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~~Trust may invest money (other than money held by it as ~~trust~~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~~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~~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~~Trust shall exercise its functions effectively, efficiently and economically.

5.2 Representative membership

5.2.1 The ~~trust~~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~~Trust, have regard to the need for those eligible for such membership to be representative of those to whom the ~~trust~~Trust provides goods and services. The ~~trust~~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~~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, and the Health and Social Care Information~~

Centre 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~~Trust shall respect the rights of members of the community it services, its employees and people dealing with the ~~trust~~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~~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~~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~~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 ~~not~~ to opt ~~in~~~~out~~ ~~to~~~~of~~ the staff membership scheme.

7.2 Public constituencies

7.2.1 There are six public constituencies covering the area of the ~~trust~~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~~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~~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~~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~~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~~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~~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~~Trust to become a member of the relevant class of the staff

constituency and have ~~not~~ informed the ~~trust~~Trust they ~~do not~~ 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~~Trust:

- 8.1.1 If, in the opinion of the Council of Governors after following proper procedures as required by the ~~trust~~Trust's ~~S~~standing ~~O~~rders, there are reasonable grounds to believe that they are likely to act in a way detrimental to the interests of the ~~trust~~Trust;

- 8.1.2 If within the last five years they have perpetrated a serious incident of violence towards any of the ~~trust~~Trust's facilities, employees or volunteers in association with their employment as defined in the ~~trust~~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~~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~~Trust) and to take such other part in the affairs of the ~~trust~~Trust as is provided in this constitution.
- 10.3 The surpluses or any profits of the ~~trust~~Trust are not to be distributed either directly or indirectly in any way at all among members of the ~~trust~~Trust.
- 10.4 Members will receive treatment by the ~~trust~~Trust on exactly the same basis as any other NHS patient.

11 The Council of Governors

- 11.1 The ~~trust~~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~~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~~^{seven} appointed Stakeholder Governors from each of the following:

~~Local Medical Committee Governors to be appointed, one from each appointed by:~~

~~11.2.3.1 Harrogate and Rural District LMC (one Governor); and;~~

11.2.3.12 Patient Experience Stakeholder Governor;

~~Local Authority Governors to be appointed, one from each appointed by:~~

11.2.3.23 North Yorkshire County Council; ~~and;~~

11.2.3.34 Harrogate Borough Council;

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

11.2.3.56 A Voluntary Organisation Governor ~~appointed by the Council of Voluntary Services (Harrogate and Ripon) appointed by a local voluntary organisation; and,~~

11.2.3.67 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~~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~~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~~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 of the Council of Governors

- 11.7.1 The Council of Governors shall elect a Deputy Chairman from amongst the elected Governors. The Deputy Chairman 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.

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~~Trust, or a ~~G~~governor or ~~D~~irector 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~~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~~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~~Trust, as defined by ~~trust~~Trust policy;
- 11.8.1.12 they are a vexatious litigant of the ~~trust~~Trust as defined by ~~trust~~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~~Trust;
- 11.8.1.14 any amount properly owing to the ~~trust~~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~~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~~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 by two-thirds majority of the remaining 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~~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~~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.

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~~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~~Trust, or is likely to be considered as a potential trading partner with the ~~trust~~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 Medical Committee;~~

11.12.3.~~34~~ an employment contract with a Local Authority;

11.12.3.~~45~~ an employment contract with an educational establishment (a university or research institute) and

11.12.3.~~56~~ 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~~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 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~~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~~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~~Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the ~~trust~~Trust or Directors' performance);

- 12.1.14 to approve any merger, acquisition, separation or dissolution application in respect of the ~~trust~~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~~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~~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~~Trust, acting in the best interest of the ~~trust~~Trust at all times.
 - 12.4 The ~~trust~~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~~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~~Trust, or in his absence, the Vice Chairman of the ~~trust~~Trust, or in exceptional circumstances in the absence of both the Chairman and Vice Chairman, the Deputy Chairman of the Council of Governors shall preside at a meeting of the Council of Governors.
- 13.2 Where a conflict of interest arises for the Chairman and Vice Chairman, the Deputy Chairman of the Council of Governors shall chair that element of the meeting. In the absence of the Deputy Chairman, the Governors shall elect from their members a Governor to chair that element of the meeting. In acting as the Chairman, a Governor shall have a casting vote on that issue.

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~~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~~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~~Trust's performance of its functions, or the Directors' performance of their duties (and deciding whether to propose a vote on the ~~trust~~Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

13.~~65~~ 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.~~76~~ 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.~~87~~ The Council of Governors is to adopt its own ~~S~~standing ~~O~~orders for its practice and procedure, in particular for its procedure at meetings, and these shall be in accordance with Annex D.

13.~~98~~ 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~~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~~ing approve the referral.

15 Annual Members' Meeting

15.1 The ~~trust~~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~~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, and~~ 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~~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~~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 ~~A~~accounting ~~O~~fficer;
 - 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~~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 ~~three quarters~~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, and 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 a governor member of the committee Deputy Chairman of Governors.

~~16.2.2~~16.2.3 That committee, ~~chaired by a Governor,~~ will recommend to the full Council of Governors no more than one individual per Non-Executive vacancy for appointment to the Board of Directors.

~~16.2.3~~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.

~~16.2.4~~ 16.2.5 The Council of Governors will have responsibility for the handling of all further aspects of the recruitment process, including any appointment.

~~16.2.5~~ 16.2.6 The ~~trust~~Trust shall publicly advertise the posts to be filled where determined by the Remuneration, and Nominations and Conduct Committee on the basis of performance or when a Non-Executive Director is approaching their final term of office.

~~16.2.6~~ 16.2.7 A long list for consideration will be identified by the Remuneration, and Nominations and Conduct Committee. Only those candidates meeting the skills and experience agreed by the Board of Directors will be eligible for appointment.

~~16.2.7~~ 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~~yes no vote.

~~16.2.8~~ 16.2.9 For the purpose of considering the appointment of the Chairman of the ~~trust~~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~~yes 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~~Trust so as to maximise the benefits for the members of the ~~trust~~Trust as a whole and for the public.

- 16.4.2 The business of the ~~trust~~Trust shall be managed by the Board of Directors who, subject to this constitution, shall exercise all the powers of the ~~trust~~Trust including:
- 16.4.2.1 to act as the critical decision making body of the ~~trust~~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~~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~~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~~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~~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~~Trust and shall act in the best interests of the ~~trust~~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~~Trust to be conducted in the absence of the Chair~~man~~, the Council of Governors will appoint by simple majority, following a recommendation from the Chairman, a Non-Executive Director to be Vice Chair~~man~~ for such a period, not exceeding the remainder of their term as a Non-Executive Director of the ~~trust~~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~~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 ~~s~~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, and 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~~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~~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~~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 ~~Q~~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~~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~~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~~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~~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~~Trust or is likely to be considered as a potential trading partner with the ~~trust~~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~~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~~Trust

- 17.1 The ~~trust~~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 ~~Secretary may be styled as the~~ Company Secretary's ~~whose~~ functions shall include responsibility for:
- 17.1.1 acting as ~~s~~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~~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~~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, ~~or opts out under the staff membership scheme,~~ and will add the name of anyone who applies to be and becomes a member.

- 18.3 The ~~trust~~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~~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~~Trust, the ~~trust~~Trust may impose a reasonable charge for doing so.

19 Public documents

- 19.1 The following documents of the ~~trust~~Trust are to be available for inspection by members of the public at all reasonable times and shall be available on the ~~trust~~Trust's website, in line with the ~~trust~~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~~Trust's affairs appointed by the Council of Governors;
 - 19.1.4 a copy of the latest annual report;
- 19.2 The ~~trust~~Trust shall also make the following documents relating to a special administration of the ~~trust~~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~~Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (~~trust~~Trusts coming out of administration) or 65LA (~~trust~~Trusts to be dissolved) of the 2006 Act;
 - 19.2.2 a copy of any report laid under section 65D (appointment of ~~trust~~Trust special administrator) of the 2006 Act;
 - 19.2.3 a copy of any information published under section 65D (appointment of ~~trust~~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 trustTrust 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 trustTrust, the trustTrust may impose a reasonable charge for doing so.

20 External auditor

- 20.1 The trustTrust 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 trustTrust'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~~Trust's performance. Any such external auditors are to be appointed by the Council of Governors.

21 Accounts

- 21.1 The ~~trust~~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~~Trust as to the content and form of the accounts.
- 21.3 The accounts are to be audited by the ~~trust~~Trust's external auditor.
- 21.4 The ~~trust~~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~~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~~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~~Trust is to prepare annual reports and send them to NHS Improvement.
- 22.2 The ~~trust~~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~~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~~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~~Trust of its principal purpose or the performance of its other functions; and

22.4.2 notify the Directors of the ~~trust~~Trust of its determination.

22.5 A ~~trust~~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~~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~~Trust at the Annual Members' Meeting with at least one member of the Board of Directors in attendance.

23.3 The ~~trust~~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 trustTrust, 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 trustTrust. The trustTrust may purchase and maintain insurance against this risk.

25 Execution of documents

- 25.1 The trustTrust 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 trustTrust'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 Sstanding Oorders 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 Sstanding Oorders 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 trustTrust voting approve the amendments; and,
- 27.1.2 More than half of the members of the Board of Directors of the trustTrust 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 result 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~~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~~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~~Trust must take such steps as are necessary as a result.

27.5 Amendments by the ~~trust~~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~~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~~Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the ~~trust~~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~~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~~Trust's overall income.

Consideration to total ~~trust~~Trust capital

The gross capital of the company or business being acquired/divested, is greater than 25% of the total capital of

the ~~trust~~Trust following completion, or the effects on the total capital of the ~~trust~~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~~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~~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~~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~~Trust maintains a website, the current address of which is:

29.2.1 www.hdft.nhs.uk

29.3 The ~~trust~~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.

DRAFT FOR APPROVAL

Annex A

1 Area of the ~~trust~~Trust

Eligibility to become a public member will be available to people living within the defined catchment area of the ~~trust~~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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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.

DRAFT FOR APPROVAL

PART 5: CONTESTED ELECTIONS

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.

DRAFT FOR APPROVAL

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.

DRAFT FOR APPROVAL

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.

FPP44.8 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.

DRAFT FOR APPROVAL

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.

DRAFT FOR APPROVAL

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~~Trust's places of business;
 - 1.3.3 by notice on the ~~trust~~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 12 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 of the Council of Governors shall preside at a meeting of the Council of Governors.

Where a conflict of interest arises for the Chairman and Vice Chairman, the Deputy Chair of the Governors shall chair that element of the meeting. In these circumstances and in the absence of the Deputy Chairman, the Governors shall elect from their members, a Governor to chair that element of the meeting. In acting as the Chairman a Governor shall have a casting vote on that issue.

3.3 Where a Governor wishes to formally pose a question at the public Council of Governors meeting, they should supply this question in

writing to the 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~~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~~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, —and 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

~~7.3 The Council of Governors will establish a remuneration committee for~~
the remuneration of the Chairman and Non-Executive Directors, and
decisions will be taken at a meeting of the Council of Governors.

7.4 The Council of Governors may, through the 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~~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~~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~~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~~Trust free of charge and within a reasonable time period of the request.

DRAFT

Standing Orders

Version	Date	Purpose of Issue/Description of Change	Review Date
1.0	Feb 2006	Initial Issue	Feb 2009
2.0	Feb 2009	Review and update	March 2012
3.0	August 2010	Update	August 2013
4.0	May 2013	Review and Update	May 2016
5.0	August 2016	Review and Update	August 2017
6.0	January 2017	Review and Update	January 2018
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Author		Company Secretary	Date
Approval and/or Ratification Body		<u>Audit Committee</u> Board of Directors	TBC <u>July 2018</u>

FOREWORD

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

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

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

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

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

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

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~~Annex A — Standing Orders of the Council of Governors~~

Annex ~~AB~~ HDFT Scheme of Reservation and Delegation

INTRODUCTION

Statutory Framework

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

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

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

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

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

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

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

NHS Framework

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

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

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

Delegation of Powers

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

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

Integrated Governance

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

Collaboration of services across West Yorkshire and Harrogate District

~~Moving to support the implementation of the Sustainable Transformation Plans (STPs),~~ acute providers are required by NHS Improvement to plan, commission and deliver efficient and sustainable healthcare services for patients across a footprint for the population of West Yorkshire and Harrogate District.

Therefore the following Trusts will collaborate to oversee a comprehensive system wide programme to deliver the objective of acute provider transformation. Collectively, they will share obligations agreed by all Parties, set out in the Memorandum of Understanding (MOU) and hold each other to account via a Committee in Common, with all Parties agreeing to its Terms of Reference.

- Airedale NHS Foundation Trust;
- Bradford Teaching Hospitals NHS Foundation Trust;
- Calderdale and Huddersfield NHS Foundation Trust;
- Harrogate and District NHS Foundation Trust;
- Leeds Teaching Hospitals NHS Trust; and
- Mid Yorkshire NHS Trust

1. INTERPRETATION

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

1.2 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, the Health and Social Care (Community Health and Standards) Act 2003, NHS Act 2006, Health and Social Care Act 2012 and other Acts relating to the National Health Service or in the Financial or other Regulations made under the Acts or in the Licence or Constitution shall have the same meaning in this interpretation and in addition:

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

"AUTHORISATION" means the authorisation of the Trust by Monitor, Healthcare Regulator (now referred to as NHS Improvement).

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

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

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

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

"COMMISSIONING" means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

"COMPANY SECRETARY" means the person responsible for supporting the board and council of governors in meeting their obligations to ensure that the foundation trust is adequately prepared to comply, and can secure ongoing compliance, with the legislative and regulatory framework.

"COMMITTEE" means a committee appointed by the Board of Directors to which the Board has delegated powers~~functioning as an internal Committee.~~

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

"COMMITTEE IN COMMON" means a collective group or representation from organisations (i.e., the acute provider Trusts in West Yorkshire and Harrogate District), to perform a particular function or duty.

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

"CONTRACTING AND PROCURING" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

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

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

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

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

"Memorandum of Understanding" (MOU or MoU) is a formal agreement between two or more Parties. Companies and organisations can use MOUs to establish official partnerships. MOUs are not legally binding but they carry a degree of seriousness and mutual respect, stronger than a gentleman's agreement.

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

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

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

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

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

"STP or Sustainability and Transformation Plans" are five year plans for the future of health and care services in local areas.

"TRUST" means Harrogate and District NHS Foundation Trust.

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

"WYAAT" means the West Yorkshire Association of Acute Trusts which includes Harrogate and District.

2. The Board of Directors

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

2.5 Composition of the Trust Board

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

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

Executive Directors including:

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

2.6 Role of the Board of Directors

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

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

(1) Executive Directors

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

(2) Chief Executive

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

(3) Director of Finance

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

(4) Non-Executive Directors

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

(5) Chairman

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

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

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

2.7 Lead Roles for Directors

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

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

2.8 Appointment of the Chair-Chairman and Non-Executive Directors

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

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

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

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

2.10 Appointment of Vice ~~Chair~~Chairman of the Board of Directors

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

Paragraph 3.1~~24~~ sets out the provision if the ~~Chair~~Chairman and Vice-~~Chair~~Chairman are absent such Non-Executive Director as the Directors present shall choose shall preside.

Any Non-Executive Director so elected may at any time resign from the office of Vice Chairman by giving notice in writing to the Chairman. The Council of Governors may thereupon appoint another Non-Executive Director as Vice ~~Chair~~Chairman in accordance with ~~paragraph 2.8~~section 16.5 of the Constitution.

2.11 Powers of the Vice Chair

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

3. MEETINGS OF THE BOARD OF DIRECTORS

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

3.13.2 ~~Members of the Board of Directors may participate in meetings by telephone, video or computer link. Participation in a meeting by any of these means shall be deemed to constitute presence in person at the meeting and they will therefore count towards to quorum.~~

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

3.43 Calling Meetings

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

- 3.54** The Chairman of the Trust may call a meeting of the Board of Directors at any time. If the Chairman refuses to call a meeting after a request for that purpose, signed by at least one-third of the whole number of Directors, has been presented, or if, without so refusing, the Chairman does not call a meeting within seven days after such request has been presented at the Trust's Headquarters, such one-third or more Directors may forthwith call a meeting.

3.65 Notice of Meetings

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

A Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust's Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

- 3.76** Lack of service of the notice on any director shall not affect the validity of a meeting.

- 3.87** In the case of a meeting called by Directors in default of the Chairman, those Directors shall sign the notice and no business shall be transacted at the meeting other than that specified in the notice.

- 3.98** Agendas will be sent to Directors no less than five working days before the meeting and supporting papers shall accompany the agenda, save in an emergency.

3.109 Setting the Agenda

The Board of Directors may determine that certain matters as a minimum shall appear on every agenda for a meeting. ~~These are:~~

- ~~—— (1) The Report from the Chief Executive.~~
- ~~—— (2) The Report from the Medical Director.~~
- ~~—— (3) The Report from the Chief Nurse.~~
- ~~—— (4) The Report from the Director of Finance.~~

~~(5) The Report from the Chief Operating Officer.~~

~~(6) The Report from the Director of Workforce and Organisational Development.~~

3.110 A Director desiring a matter to be included on an agenda shall make a request to the Company Secretary at least seven working days before the meeting. This request will be discussed with the Chairman and Chief Executive. Requests made less than seven working days before a meeting may be included on the agenda at the discretion of the Chairman.

3.124 Chair of Meeting

At any meeting of the Board of Directors the Chairman, if present, shall preside. If the ~~Chair-Chairman~~ is absent from the meeting the Vice ~~Chair-Chairman~~ shall preside. If the ~~Chair-Chairman~~ and Vice ~~Chair-Chairman~~ are absent such Non-Executive Director as the Directors present shall choose shall preside.

3.132 If the ~~Chair-Chairman~~ is absent from a meeting temporarily on the grounds of a declared conflict of interest the Vice-Chairman, if present, shall preside. If the ~~Chair-Chairman~~ and Vice-~~Chair-Chairman~~ are absent, or are disqualified from participating, such Non-Executive Director as the directors present shall choose shall preside.

3.143 Notices of Motion

A director desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

3.154 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

3.165 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding ~~six~~⁶ calendar months shall bear the signature of the director who gives it and also the signature of ~~four~~⁴ other directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the ~~Chair-Chairman~~ to propose a motion to the same effect within ~~six~~⁶ months.

3.176 Motions

The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.187 When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceed to the next business.
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion is discussed at the meeting.

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.198 Chair's Ruling

Statements of Directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity, and any other matters shall be observed at the meeting.

3.1209 Voting

Every question put to a vote at a meeting shall be determined by a majority of the votes of the Chair of the meeting and directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

3.210 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

3.224 If at least four of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

3.232 If a director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.243 In no circumstances may an absent director vote by proxy. Absence is defined as not being able to participate in the meeting at the time of the

vote. In accordance with Standing Order 3.2 Participation can take place by telephone, video or computer link~~teleconference or video conference~~.

3.254 An officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An officer attending to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

3.265 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

3.276 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.287 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of the meeting the minutes shall be made available to the public ~~(required by Code of Practice on Openness in the NHS and the Freedom of Information Act)~~. A record of items discussed in private will be maintained and approved by the Board of Directors.

3.298 Suspension of Standing Orders

Except where this would contravene any statutory provision or any provision of the Licence or of the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board of Directors are present, including two Executive Directors and two Non-Executive Directors, and that a majority of those present vote in favour of suspension.

3.3029 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.310 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.

3.324 No formal business may be transacted while Standing Orders are suspended.

3.332 The Audit Committee shall review every decision to suspend Standing Orders.

3.343 Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

- a notice of motion under Standing Order 3.16 has been given; and
- no fewer than half of the Trust's total Non-Executive Directors in post vote in favour of amendment; and
- at least two-thirds of the Directors are present; and
- the variation proposed does not contravene a statutory provision or provision of the licence or of the Constitution

3.354 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

3.365 Quorum

No business shall be transacted at a meeting of the Board of Directors unless at least ~~six-five~~ of the whole number of the Directors are present including at least ~~three-two~~ Executive Directors and three Non-Executive Directors, one of whom is the Chair~~man~~ and as such has a casting vote.

3.376 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum (see Standing Order 3.25).

3.387 If the Chair~~man~~ or ~~a D~~director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Orders 6 and 7) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least ~~two~~~~three~~ Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to a provision in the Licence or the Constitution, the Board of Directors may make arrangements for the exercise, on its behalf of any of its functions

- by a committee or sub-committee.
- appointed by virtue of Standing Order 5.1 or 5.2 below or by a director ~~or an officer~~ of the Trust

in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

4.2 Emergency Powers

The powers which the Board of Directors has retained to itself within these Standing Orders (Standing Order 2.2) may in emergency be exercised by the Chief Executive and the ~~Chair~~Chairman after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the ~~Chair~~Chairman shall be reported to the next formal meeting of the Board of Directors for ratification.

4.3 Delegation to Committees

The Board of Directors shall agree, as and when it deems appropriate, to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The Constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

4.4 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on its behalf by the Chief Executive. The Chief Executive shall determine which functions shall be delegated to officers to undertake

4.5 The Chief Executive shall prepare a Scheme of Reservation and Delegation (Annex A) identifying proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Reservation and Delegation, which shall be considered and approved by the Board of Directors as indicated above.

4.6 Nothing in the Scheme of Reservation and Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance or other Executive Director to provide information

and advise the Board of Directors in accordance with any statutory requirements. Outside these statutory requirements the roles of the Director of Finance, Chief Operating Officer, Medical Director, Chief Nurse and Director of Workforce and Organisational Development shall be accountable to the Chief Executive for operational matters.

- 4.7** The arrangements made by the Board of Directors as set out in the "Harrogate and District NHS Foundation Trust Scheme of Reservation and Delegation" shall have effect as if incorporated in these Standing Orders [\(see Annex A\)](#).

5. COMMITTEES

5.1 Appointment of ~~Internal Committees~~ (~~committee~~)

Subject to the Licence, and the Constitution, the Board of Directors may ~~– delegate any of its powers to a committee of the Board (comprised of a group of Board Directors). appoint internal committees of the Trust, or together with one or more stakeholder or other Trusts, appoint joint committees, consisting wholly or partly of the Chair and Directors of the Trust or other health service bodies or wholly of persons who are not Directors of the Trust or other health service bodies in question.~~

5.2 An ~~internal committee or joint committee~~ appointed under this regulation may, in accordance with the Constitution, appoint sub-committees consisting ~~comprised of a group of Board Directors.~~

~~wholly or partly of Directors of the internal committee or joint committee (whether or not they are Directors of the Trust or other health service bodies in question); or wholly of persons who are not Directors of the Trust or other health service bodies or the committee of the Trust or other health service bodies in question.~~

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

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

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

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

5.7 Membership of the WYAAT Committee in Common will be defined in the Term of Reference, which will be agreed or amended by all Parties. The Board of Harrogate and District NHS Foundation Trust has not agreed to delegate any of its statutory functions to the Committee in Common. The scope of the Committee in Common will be responsible for leading the development of the WYAAT Collaborative Programme and the work streams in accordance with the defined key principles, setting the overall strategic direction, in order to deliver the WYAAT Collaborative Programme.

5.8 The committees and sub-committees established by the Trust are:

5.8.1 The Audit Committee;

5.8.2 The Remuneration and Nominations Committee for Executive Directors;

~~5.8.3 The Nominations Committee for Executive Directors;~~

5.8.~~34~~ The Charitable Funds ~~Investment Panel~~Committee

5.8.~~45~~ The Quality Committee

5.8.~~56~~ The Finance Committee

5.8.6 The Senior Management Team

Such other committees may be established, as required, to discharge the Board's responsibilities. A diagram detailing the Trust's governance structure can be found on the Trust intranet ~~by following:~~ <http://nww.hdft.nhs.uk/corporate/departments/governance-and-risk-management/strategy-policies-and-protocols/>

The minutes of the above committees will be made available to the Board of Directors at their meetings, with the exception of the Remuneration and Nominations Committee; these meetings will be referenced by the Chairman at Board of Directors meetings however the full minutes will not be shared due to the confidential nature of discussions.

5.8 Confidentiality

A member of a formal subcommittee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

5.9 A director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or

action has been concluded, if that Board or committee shall resolve that it is confidential.

DRAFT FOR APPROVAL

6. DECLARATIONS OF INTERESTS

6.1 Declaration of Interests - The Constitution requires members of the Board of Directors to declare interests, which are relevant and material to the Board of Directors (including membership of the WYAAT Committee in Common). All existing directors should declare such interests. Any directors appointed subsequently should do so on appointment.

6.2 Interests, which should be regarded as “relevant and material”, are:

- a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies).
- b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
- c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
- d) A position of authority in a charity or voluntary organisation in the field of health and social care.
- e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.
- f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

Board members are expected to declare any personal or business interest which may influence, or may be *perceived* to influence, their judgement.

6.3 At the time directors' interests are declared, they should be recorded in the Board of Directors' minutes. Any changes in interests should be officially declared at the next Board of Directors meeting following the change occurring.

6.4 Directors' Directorships of companies in 6.2.a) above likely or possibly seeking to do business with the NHS (6.2.b) above) should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports. Any changes in interests should be officially declared at the next board meeting as appropriate following the change occurring. It is the obligation of the

director to inform the Company Secretary of the NHS Foundation Trust in writing within seven days of becoming aware of the existence of a relevant or material interest. The Company Secretary will amend the Register upon receipt of interests within three working days.

- 6.5** During the course of a Board of Directors meeting, if a conflict of interest is established, the Chairman will determine whether the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, majority will resolve the issue with the ~~Chair~~Chairman having the casting vote.
- 6.6** WYAAT Committee in Common – the Chairman and Chief Executive (and nominated deputies) of Harrogate and District NHS Foundation Trust will adhere to declaring interests as described in Section 10 of the WYAAT Committee in Common Memorandum of Understanding.
- 6.7** If directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chairman or the Company Secretary. ~~The appropriate Financial Reporting Standard (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest.~~ The interests of partners in professional partnerships including general medical practitioners should also be considered.
- 6.8** Supporting guidance relating to declaration of interests can be found in the Trust's ~~C~~onstitution and the Conflicts of Interest Policy.

7. ~~DISABILITY OF CHAIRMAN AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF A MATERIAL PECUNIARY INTEREST~~

7.1 Subject to the following provisions of this Standing Order, if the ~~Chair~~ Chairman or a ~~D~~director of the Trust has any ~~material~~pecuniary interest (as defined by the Constitution), direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Board of Directors will exclude the ~~Chair~~Chairman or a ~~D~~director of that Board from a meeting of that Board while any contract, proposed contract or other matter in which he has a ~~pecuniary~~material interest, is under consideration.

7.3 Any remuneration, compensation or allowances payable to the ~~Chair~~ Chairman or a Non-Executive Director in accordance with the Constitution shall not be treated as a ~~material~~pecuniary interest for the purpose of this Standing Order.

7.4 For the purpose of this Standing Order the Chairman or a director shall be treated, subject to Standing Orders 7.2 and 7.6, as having indirectly a ~~pecuniary~~material interest in a contract, proposed contract or other matter, if:

(a) he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct ~~material~~pecuniary interest in the other matter under consideration;

or

(b) he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct ~~material~~pecuniary interest in the other matter under consideration;

and in the case of persons living together as partners the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.5 The ~~Chair~~Chairman or a ~~D~~director shall not be treated as having a ~~pecuniary~~material interest in any proposed contract or other matter by reason only:

- (a) of membership of a company or other body, if there is no beneficial interest in any securities of that company or other body;
- (b) of an interest in any company, body or person with which he is connected as mentioned in Standing Order 7.4 above which is so remote or insignificant that it cannot reasonably be regarded by the Board as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.6 Where the Chairman or a Dedirector:

- (a) has an indirect pecuniary-material interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body:
- (b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less: and
- (c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it (without prejudice however to his/her duty to disclose his/her interest) provided the interest has been declared.

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

8. **STANDARDS OF BUSINESS CONDUCTCONFLICTS OF INTEREST**

8.1 **Policy**

Staff must comply with the ~~national guidance contained in HSG(93)5 "Standards of Business Conduct for NHS staff" (contained in the Trust Code of Business Conduct).~~Trust's Conflicts of Interest Policy. The following provisions should be read in conjunction with this document.

8.2 **Interest of Officers in Contracts**

If it comes to the knowledge of a Director or an Officer of the Trust that a contract in which he/she has any pecuniary-material interest (but not being a contract to which he/she is himself/herself a party), has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in accordance with the Trust's Conflicts of Interest Policy writing to the Chief Executive of the fact that he/she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.3 An officer must also declare in accordance with the Trust's Conflicts of Interest Policy to the Chief Executive any other employment or business or other relationship of his/hers, or of a cohabiting partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Trust requires interests, employment or relationships so declared by staff to be entered in a register of interests of staff.

8.4 **Canvassing of, and Recommendations by, Directors in Relation to Appointments**

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

8.5 A Director shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust or taking part in the appointment process.

8.6 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.7 Relatives of Directors or Officers

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

8.8 The Chairman, Directors and every officer of the Trust shall disclose in accordance with the Trust's Conflicts of Interest Policy ~~to the Chief Executive~~ any relationship with a candidate of whose candidature that Director or officer is aware. ~~It shall be the duty of Line Managers to report to the Trust any such disclosure made. Relationships to which this order applies are those of husband and wife or co-habitees or where either of the two or the spouse of either of them is the son or daughter or grandson or granddaughter or brother or sister or nephew or niece of the other or the spouse of the other.~~

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

8.10 Where the relationship of an officer or another Director to a Director of the Trust is disclosed, the Standing Order headed "Disability of the Chair Chairman and Directors in proceedings on account of pecuniary material interest" (Standing Order 7) shall apply.

8.11 On appointment to the Trust, all Directors will be required to fulfil the requirements of the Fit and Proper Persons Test.

9. IN-HOUSE SERVICES

- 9.1** In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:
- (a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.
 - (b) In-house tender group, comprising a nominee of the Chief Executive and technical support.
 - (c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £500,000, a Non- Executive Director should be a member of the evaluation team.
- 9.2** All groups should work independently of each other and individual officers may be a director of more than one group but no director of the in-house tender group may participate in the evaluation of tenders.
- 9.3** The evaluation team shall make recommendations to the Board of Directors.
- 9.4** The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

10. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

10.1 Custody of Seal

The Common Seal of the Trust shall be kept by the Chief Executive, or officer appointed by him/her, in a secure place.

10.2 Sealing of Documents

The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or a committee thereof or where the Board of Directors has delegated its powers. The affixing of the Seal shall be attested and signed by the Chairman (or in his/her absence a Non-Executive Director) and the Chief Executive (or in his/her absence his/her deputy).

In the event of a requirement to affix the seal prior a meeting of the Board of Directors or a committee where the Board has delegated its powers, and at the agreement of the Chairman and Chief Executive, the authorisation to affix the seal can be given retrospectively by the Board of Directors. This is applicable only when prior authorisation to proceed with the project in question has been granted by the Board of Directors.

10.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by him/her) and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating directorate).

10.4 Register of Sealing

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing). The book will be held by the Company Secretary.

11.

SIGNATURE OF DOCUMENTS

- 11.1** Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.
- 11.2** The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which that Board has delegated appropriate authority.

12. MISCELLANEOUS

12.1 Standing Orders to be given to Directors and Officers

It is the duty of the Chief Executive to ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

12.2 Documents having the standing of Standing Orders

Standing Financial Instructions, Reservation of Powers to the Board of Directors and Delegation of Powers shall have effect as if incorporated into Standing Orders.

12.3 Review of Standing Orders

Standing Orders shall be reviewed at annual intervals by the Board of Directors, or as required following organisational structure or policy change. The requirement for review extends to all documents having effect as if incorporated in Standing Orders.

12.4 Overriding Standing Orders

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

12.5 Joint Ventures (Contractual and Corporate)

The Executive Directors shall be authorised to develop commercial opportunities which may (or may not) lead to the establishment of a joint venture, either contractual or corporate. The Executive Directors shall keep the Board apprised of the subject matter via the Chief Executive (or nominated officer).

A joint venture, either contractual or corporate, shall not be entered into unless authorised by the Board of Directors of Harrogate and District NHS Foundation Trust.

ANNEX A**~~Council of Governors~~
~~Standing Orders~~****~~1. NOTICE~~**

~~1.1 The Council of Governors is to meet at least three times in each financial year in addition to the Annual Members' Meeting. Save in the case of emergencies or the need to conduct urgent business, the 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 12 Governors entitled to vote at the meeting, with the majority of Governors from the public constituencies.~~

~~2.2 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine and notice of the adjourned meeting shall be circulated to members of the Council of Governors. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of Governors present during the meeting is to be a quorum.~~

~~3. CONDUCT OF MEETING~~

~~3.1 It is the responsibility of the Council of Governors, the Chairman of the meeting and the Company Secretary to ensure that at any meeting:~~

~~3.1.1 the issues to be decided are clearly explained;~~

~~3.1.2 sufficient information is provided to Governors to enable rational discussion to take place; and~~

~~3.1.3 where appropriate, experts in relevant fields or representatives of special interest groups are invited to address the meeting.~~

~~3.2 The Chairman of the Trust, or in their absence, the Vice Chairman of the Trust, or in exceptional circumstances in the absence of both the Chairman and Vice Chairman, the Deputy Chairman of the Council of Governors shall preside at a meeting of the Council of Governors.~~

~~Where a conflict of interest arises for the Chairman and Vice Chairman, the Deputy Chair of the Governors shall chair that element of the meeting. In these circumstances and in the absence of the Deputy Chairman, the Governors shall elect from their members, a Governor to chair that element of the meeting. In acting as the Chairman a Governor shall have a casting vote on that issue.~~

~~3.3 Where a Governor wishes to formally pose a question at the public Council of Governors meeting, they should supply this question in writing to the 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, every Governor is to have one vote and in no circumstances may an absent Governor vote by proxy. In the case of an equality of votes the Chairman of the meeting is to have a casting vote, unless there is a conflict of interest as set out in 3.2. in which case the acting chairman will have both a primary and a casting vote.~~

~~4.3 Unless a poll is demanded, the result of any vote will be declared by the Chairman and entered in the minutes of the meeting. The minutes will be conclusive evidence of the result of the vote.~~

~~4.4 A poll may be directed by the Chairman or demanded either before or immediately after a vote by show of hands by not less than one-tenth of the Governor present at the meeting. A poll shall be taken immediately.~~

~~4.5 Subject to the following provisions of this paragraph, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes.~~

~~4.5.1 no resolution of the Council of Governors shall be passed if all the Public Governors present unanimously oppose it.~~

~~4.5.2 the removal of the Chairman or another Non-Executive Director requires the approval of three-quarters of the full membership of the Council of Governors.~~

~~4.6 Save as set out in 4.2 the Chairman of the Council of Governors or Vice Chairman shall not have a vote at a meeting of the Council of Governors.~~

~~5 PERSONS ENTITLED TO ATTEND MEETINGS~~

~~5.1 All meetings of the Council of Governors are to be open to the public unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds as set out in the Constitution. The Chairman may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.~~

~~5.2 The Council of Governors may invite the Chief Executive or any other representatives of the Board of Directors, or a representative of the~~

~~trust's external auditors or other advisors to attend a meeting of the Council of Governors.~~

~~5.3 The Chief Executive and any other Director will be invited to attend all meetings of the Council of Governors.~~

~~6. MEANS OF ATTENDANCE~~

~~6.1 The Council of Governors may agree that its Governors can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.~~

~~7. COMMITTEES~~

~~7.1 The Council of Governors may form advisory sub-committees under written terms of reference to the Council of Governors which may include members of the Board of Directors and appropriate people (paid or unpaid) nominated by the Board of Directors and having relevant skills or experience. Those powers shall be exercised in accordance with any written instructions given by the Council of Governors. The Council of Governors will appoint the Chairman of any committee and shall specify the quorum. All acts and proceedings of any committee shall be reported to the Council of Governors.~~

~~7.2 The Council of Governors will establish a Nominations Committee for the purpose of making recommendations to the Council of Governors for the appointment of the Chairman and Non-Executive Directors.~~

~~7.3 The Council of Governors will establish a remuneration committee for the remuneration of the Chairman and Non-Executive Directors, and decisions will be taken at a meeting of the Council of Governors.~~

~~7.4 The Council of Governors may, through the 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.~~

HARROGATE AND DISTRICT NHS FOUNDATION TRUST SCHEME OF RESERVATION AND DELEGATION

REFERENCE (Where applicable)		DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	General Enabling Provision The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
NA	THE BOARD	Regulations and Control 1. Approve <u>the Constitution (alongside the Council of Governors)</u> Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 3.4. <u>Ratify any emergency decisions taken by the Chairman and Chief Executive at the next formal public meeting of the Board in accordance with SO 4.2.</u> 4.5. Approve a scheme of delegation of powers from the Board to committees. 5.6. Require and receive the declarations of Directors' interests that may conflict with those of the Trust and determining the extent to which that Director may remain involved with the matter under consideration. 6.7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 7.8. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 8.9. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 9.10. Confirm the recommendations of the Trust's committees where the committees do not have <u>executive-the necessary</u> powers. 10.11. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for charitable funds held on trust. 11.12. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 12.13. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for

REFERENCE (Where applicable)		DECISIONS RESERVED TO THE BOARD
		<p>patients' property.</p> <p>13.14. Authorise <u>and monitor</u> use of the seal.</p> <p>14.15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention</p> <p><u>16. Discipline members of the Board or employees who are in breach of statutory requirements or SOs in accordance with the Trust's disciplinary procedures.</u></p> <p><u>17. Authorise the Trust to enter any joint ventures, either contractual or corporate.</u></p> <p><u>18. Authorise the establishment of any subsidiary companies of the Trust.</u></p> <p>15.</p>
NA	THE BOARD	<p>Appointments/ Dismissal</p> <p><u>1. Nomination of the Vice Chairman of the Trust for ratification by the Council of Governors.</u></p> <p><u>2. Appoint the Senior Independent Director following consultation with the Council of Governors.</u></p> <p>1.3. Appoint and dismiss committees (and individual members) that are directly accountable to the Board.</p> <p>2.4. Appoint, appraise, discipline and dismiss <u>the Executive Directors</u>Chief Executive.</p> <p>3.5. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.</p> <p>4. Approve proposals of the Remuneration <u>and Nominations</u> Committee regarding Directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration <u>and Nominations</u> Committee.</p> <p><u>5. Ensure that appropriate succession planning is carried out for the Board and senior management team.</u></p>
NA	THE BOARD	<p>Strategy, Plans and Budgets</p> <p><u>1. Define the Trust's mission, values and strategic aims and objectives of the Trust.</u></p> <p><u>1.2. Ensure that a Board development and organisational development plans are in place to support the Trust's delivery of the strategic direction.</u></p> <p>2.3. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust.</p> <p>3.4. Approve the Trust's policies and procedures for the management of risk.</p> <p>4.5. Approve Outline and Final Business Cases for Capital Investment, <u>in line with financial limits defined within the Trust's Standing Financial Instructions.</u></p> <p>5.6. Approve <u>annually the Trust's operational plan, operational budgets, and capital programme.</u></p> <p>6.7. Approve annually Trust's proposed organisational development proposals.</p>

REFERENCE (Where applicable)		DECISIONS RESERVED TO THE BOARD
		<p>7-8. Ratify proposals for acquisition, disposal or change of use of land and/or buildings.</p> <p>8-9. Approve PFI proposals.</p> <p>9-10. Approve the opening of bank accounts.</p> <p>10-11. Approve proposals for borrowing.</p> <p>11-12. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board.</p> <p>12. Approve proposals for action on litigation against or on behalf of the Trust.</p> <p>13.</p>
NA	THE BOARD	<p>Policy Determination</p> <p>1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.</p>
NA	THE BOARD	<p>Audit</p> <p>1. Receive of the annual audit letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.</p> <p>2. Receive an annual report from the Internal Auditor Audit Committee and agree action on recommendations where appropriate of the Audit Committee.</p> <p>4-3. Approve the appointment (and where necessary the dismissal) of internal auditors.</p>
NA	THE BOARD	<p>Annual Reports and Accounts</p> <p>1. Receipt and approval of the Trust's Annual Report, Quality Account and Annual Accounts.</p> <p>2. Receipt and approval of the Annual Report and Accounts for funds held on trust.</p>
NA	THE BOARD	<p>Monitoring</p> <p>1. Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated.</p> <p>2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by Monitor NHS Improvement and the Charity Commission shall be reported, at least in summary, to the Board.</p>

REFERENCE (Where applicable)		DECISIONS RESERVED TO THE BOARD
		<p><u>2.3. Ensure maintenance of a sound system of internal control and risk management which holds the organisation to account for the delivery of the strategy and seeks assurance that systems of internal control are robust and reliable.</u></p> <p><u>3.4. Ensure that the necessary financial, human and physical resources are in place to enable the Trust to meet its priorities and objectives and periodically review management performance, including through reports from the Director of Finance on financial performance against budget and contracts agreed with commissioners. Receive reports from the Director of Finance on financial performance against budget and Local Delivery Plan.</u></p>
<u>NA</u>	<u>THE BOARD</u>	<p><u>Clinical Standards and Patient Safety</u></p> <ol style="list-style-type: none"> <u>1. Ensure compliance with all legal and regulatory requirements and clinical guidance monitoring performance against the Care Quality Commission requirements and ensuring that effective systems operate for the dissemination of National Guidance and directives.</u> <u>2. Ensure a focus on quality at strategic and operational levels including patient safety (including Healthcare Associated Infections), effectiveness and patient experience as well as the promotion of health and wellbeing.</u>
<u>NA</u>	<u>THE BOARD</u>	<p><u>Harrogate Healthcare Facilities Management Limited (a wholly owned subsidiary company of the Trust)</u></p> <ol style="list-style-type: none"> <u>1. Approving and signing off plans for the strategic direction of the Company.</u> <u>2. Approving the Company's annual business plan.</u> <u>3. Deciding whether the Company should incur expenditure outside the annual business plan which exceeds 1% of the projected budget.</u> <u>4. Deciding whether the Company should join, leave, establish or wind-up any pension scheme or materially alter participation in or, where relevant, the terms of any existing pension scheme.</u> <u>5. Deciding whether the Company should take out any borrowings, except for normal trade credit in the ordinary course of business, except as contemplated in the annual business plan.</u> <u>6. Deciding whether the Company should make any significant change in the nature of the business of the Company, except as contemplated in the annual business plan.</u> <u>7. Deciding whether the Company should enter into, vary, renew or terminate any contract or other arrangement which exceeds the term of the Operated Healthcare Facilities Agreement with the Trust.</u> <u>8. Deciding whether the Company should enter into any partnership or joint venture arrangement or vary or terminate any existing arrangement, or establish any subsidiary except as contemplated in the annual business plan or a separately approved business case.</u>

REFERENCE (Where applicable)		DECISIONS RESERVED TO THE BOARD
		<p><u>9. Deciding whether the Company should acquire or dispose of any patent, trademark, registered design or other know-how or any intellectual property rights.</u></p> <p><u>10. Deciding whether the Company should give or create any guarantee, indemnity, mortgage, or charge over its business, assets or undertakings or sell, discount or otherwise dispose of any of its book or other debts owing to it from time to time, except early payment discounts given in the ordinary course of business, except as contemplated in the annual business plan or any separately approved business case.</u></p> <p><u>11. Deciding whether to pass any resolution or take any other corporate action for the winding up of the Company.</u></p> <p><u>12. Following a decision by the ASDM's board of directors as to the level of a dividend, deciding whether the Company should pay any dividend or make any other distribution.</u></p> <p><u>13. Deciding whether to change the Company's accounting reference period.</u></p> <p><u>14. Setting the Company's accounting policies and deciding whether to change them.</u></p> <p><u>15. Deciding whether the Company should acquire or agree to acquire any freehold or leasehold interest in or license over land.</u></p> <p><u>16. Deciding whether the Company should sell, lease, license, transfer or otherwise dispose of any of its assets at a total price per transaction exceeding.</u></p> <p><u>17. Approving any outsourcing arrangement or agreement (including by way of subcontract) in respect of the Company, where such arrangement or agreement will, or may, result in the TUPE transfer of staff employed by the Company to a third party.</u></p>

<u>REFERENCE</u> <u>(Where applicable)</u>		<u>DECISIONS RESERVED TO THE COUNCIL OF GOVERNORS</u>
<u>Constitution section 12.1</u>		<u>Regulations and Control</u> <ol style="list-style-type: none"> 1. <u>Approve the Trust's Constitution (alongside the Board of Directors).</u> 2. <u>Appoint, or remove, the Trust's external auditor selected from an approved list put forward by the Board of Directors.</u> 3. <u>Appointment, and as required removal, of the Chairman and the other Non-Executive Directors.</u> 4. <u>Approve appointment (by the Non-Executive Directors) of the Chief Executive.</u> 5. <u>Appoint the Vice Chairman of the Trust.</u> 6. <u>Appoint the Deputy Chairman of the Council of Governors</u> 7. <u>Agree decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and Non-Executive Directors</u> 8. <u>Approve the Trust's Membership Development Strategy.</u> 9. <u>Approve any merger, acquisition, separation or dissolution application in respect of the Trust before the application is made to NHS Improvement.</u> 10. <u>Approve the entering into of any significant transactions.</u> 11. <u>Approve the referral of a question by a Governor to any panel appointed by NHS Improvement</u> 12. <u>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.</u>

DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 2.1	AUDIT COMMITTEE	<p><u>1.</u> The Audit Committee will provide an independent and objective view of internal control by:</p> <ul style="list-style-type: none"> (a) reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trusts activities (both clinical and non-clinical) that supports the achievements of the Trusts objectives. (b) ensuring there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards, liaises appropriately with external audit and provides appropriate, independent assurance to the Audit Committee, Chief Executive and Board. (c) reviewing the work and findings of the External Auditor appointed by the Council of Governors and considering the implications and management's response to their work. (d) reviewing the findings of the other significant assurance functions both internal and external to the Trust and considering the implications to the governance of the organisation. (e) reviewing the Annual Report and Financial Statements before submission to the Board.
SFI 2.1.3		<u>2.</u> The Audit Committee shall be involved in the selection process when there is a proposal to review the provision of internal audit services.
SFI 5.6.2		<u>3.</u> The <u>Audit Committee will receive a report from the</u> Finance Director, <u>will report</u> at least every 5 years, on the review of banking services <u>to the Audit Committee</u> .
SFIs 9.5.2 and 9.5.3		<u>4.</u> The Audit Committee will review all instances of non-competitive procurement (single tender actions) for reasons (c) – (f) of SFIs 9.5.2 and 9.5.3
SFI 12.2.7		<u>5.</u> The Audit Committee will review the Losses & Special Payments Register on an annual basis
SO 3.32		<u>6.</u> The Audit Committee will review every decision to suspend Standing Orders.

<p>SFI 8.1.2</p> <p>SFI 8.1.3</p>	<p>REMUNERATION AND NOMINATIONS (AND TERMS OF SERVICE) COMMITTEE</p>	<p>1. The Remuneration (and Terms of Service)and Nominations Committee will:</p> <p>(a) Advise the Board of Directors<u>Reach decisions</u> about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors employed by the Trust and other senior employees including:</p> <ul style="list-style-type: none"> (i) all aspects of salary (including any performance-related elements/bonuses); (ii) provisions for other benefits, including pensions and cars; (iii) arrangements for termination of employment and other contractual terms; <p>(b) Make such recommendations to the Board of Directors on the remuneration and terms of service of the Board of Directors (and other senior employees) to<u>E-ensure Executive Directorsthey</u> are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate; and</p> <p>(c) Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.</p> <p>The Committee shall report in writing to the Board of Directors the basis for its recommendations. The Board of Directors shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board of Directors' meetings should record such decisions.</p>
<p>N/A</p>	<p>CHARITABLE FUNDS INVESTMENT PANELCOMMITTEE</p>	<p>The Charitable Funds Investment PanelCommittee has responsibility for:-</p> <ol style="list-style-type: none"> 1. <u>Overseeing development of the charity's strategy and objectives for the Charity (including the Fundraising Strategy) for consideration by the TrustBoard (corporate trustee).</u> 2. <u>Acting as the committee which discharges the Trust Board's responsibilities (as corporate trustee) as they relate to Charitable Funds under the Trust's custodianship.</u> 3. <u>Ensuring that the charitable funds held by the Trust (as corporate trustee) are managed in a manner consistent with the requirements of the relevant regulatory and statutory frameworks and in accordance with the guidance on NHS Charities set out by the Charity Commission.</u> 4. <u>Acting solely in the best interests of Harrogate Hospital and Community Charity and in a manner consistent with the Charity Commission's requirements and expectations of Charity Trustees.</u> 5. <u>Monitoring the performance of fundraising and marketing activity, ensuring that the return on investment is satisfactory and that income targets are met.</u>

		<p><u>6. Overseeing the Charity's strategy, governance, major plans and key risks on behalf of the Corporate Trustee.</u></p> <p><u>7. Establishing, prioritising and approving major fundraising projects. See financial standing investments for the full list of authority levels.</u></p> <p><u>8. Devising and implementing an investment strategy for the Charity, including the appointment and monitoring of any investment managers. Receive reports for ratification from the Finance Director on investment decisions and action taken through delegated powers upon the advice of the Trust's investment advisor.</u></p> <p><u>9. Ensuring submission of the Annual Accounts and Trustees' report in accordance with the Charity Commission's Statement of Recommended Practice.</u></p> <p>1.The retrospective authorisation of income/expenditure for items below £5,000, with details shown for all individual items over £500 (it should be noted that the limits and rules concerning delegated authority applies to all expenditure)</p> <p>2.The authorisation in advance of income/expenditure for items above £5,000, but below £150,000 (as above £150,000 Trustees approval is required);</p> <p>3.Review of the financial position of the charity; including balance sheet, income and expenditure and cash flow;</p> <p>4.Reviewing the performance of the investments and the cash requirements of the charity (the panel members receive a quarterly Information and Investment report from the investment managers – Brewin Dolphin)</p> <p>5. Any other activities relevant to the administration of the trust funds (including the completion and filing of annual report and accounts); in accordance with the trustee's wishes.</p>
<u>NA</u>	<u>QUALITY COMMITTEE</u>	<p><u>The Quality Committee has responsibility for:</u></p> <p><u>1 Showing leadership in setting a culture of continuous improvement in delivering high quality care.</u></p> <p><u>2 Overseeing preparation of the Quality Account prior to approval by the Board of Directors and submission to NHS Improvement.</u></p> <p><u>3 Reviewing systems, processes and outcomes* in relation to:</u></p> <ul style="list-style-type: none"> <u>• Delivery of the Trusts objectives in relation to quality and annual quality improvement priorities;</u> <u>• Quality performance and outcome measures relating to fundamental care, including the impact of cost improvement plans;</u> <u>• Staff metrics that impact on quality i.e. staff vacancies, statutory and mandatory training, induction, appraisal and sickness;</u> <u>• CQC registration and compliance with fundamental standards in acute and community services;</u> <u>• Organisational learning as a result of incidents, SIRIs, complaints, concerns and claims;</u>

		<ul style="list-style-type: none"> • <u>Organisational learning and improvement as a result of patient and staff feedback from national and local surveys including FFT, and patient safety visits;</u> • <u>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.</u> • <u>Research and development, quality improvement and innovation, including rapid process improvement workshops and delivery of CQUIN.</u> <p>4. <u>Receive key reports for example:</u></p> <ul style="list-style-type: none"> • <u>Infection prevention and control annual report;</u> • <u>Local Supervising Authority audit report;</u> • <u>Maternity screening report;</u> • <u>Health and Safety annual report;</u> • <u>Patient experience including complaints, concerns and compliments annual report;</u> • <u>Staff survey as it relates to the quality of care.</u>
<u>NA</u>	<u>FINANCE COMMITTEE</u>	<p><u>The Finance Committee has responsibility for:</u></p> <ol style="list-style-type: none"> 1. <u>Supporting the Board in scrutinising financial performance and operational activity levels (excluding performance against operational standards).</u> 2. <u>Scrutinising the development of the Trust's financial and commercial strategy, both revenue and capital.</u> 3. <u>Scrutinising the assumptions and methodology used in developing the financial strategy, including activity modelling and efficiency assumptions.</u> 4. <u>Recommending to the Board the financial plan for submission to NHS Improvement.</u> 5. <u>Scrutinising and ensuring appropriate due diligence is undertaken in relation to any significant transactions as defined by NHS Improvement</u> 6. <u>Scrutinising the annual Cost improvement Programme and review the impact on the Trust.</u> 7. <u>Ensuring that annual financial plan is consistent with financial strategy.</u> 8. <u>Scrutinising the Trust budget prior to approval by the Board.</u> 9. <u>Reviewing the capital programme in line with the financial plan.</u> 10. <u>Reviewing activity plans in line with the financial planning assumptions.</u> 11. <u>Reviewing quarterly financial performance before submission to NHS Improvement</u> 12. <u>Assessing the impact of financial performance on the Financial Services Risk Rating</u> 13. <u>Overseeing implementation of service line reporting</u> 14. <u>Reviewing service line information, profitability of service lines and the impact of activity delivery on financial performance</u> 15. <u>Undertaking 'deep dive' reviews of appropriate sections of the Board Assurance Framework</u> 16. <u>Undertaking any relevant matter as requested by the Board of Directors</u>

DRAFT FOR APPROVAL

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTING OFFICER MEMORANDUM (~~Monitor~~ 2008)

REF	DELEGATED TO	DUTIES DELEGATED
7	CHIEF EXECUTIVE	Responsibility for the overall organisation, management and staffing of the NHS foundation trust Trust and for its procedures in financial and other matters.
8	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	<ul style="list-style-type: none"> • The propriety and regularity of the public finances for which he or she is answerable • The keeping of proper accounts • Prudent and economical administration <u>in line with the principles set out in <i>Managing public money</i></u> • The avoidance of waste and extravagance and • The efficient and effective use of all the resources in their charge
9	CHIEF EXECUTIVE	<ul style="list-style-type: none"> • Signing of the accounts, accepting personal responsibility for ensuring their proper form and content as prescribed by MonitorNHS Improvement • Comply with the financial requirements of the terms of authorisationthe NHS provider license • <u>Ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS Foundation Trust)</u> • <u>Ensure that the resources are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official</u> • <u>Ensure that assets such as land, buildings or other property, including stores and equipment are controlled and safeguarded with care, and with checks as appropriate</u>properly and well managed and safeguarded • Ensure that assets such as land, buildings or other property, including stores and equipment, are controlled and safeguarded • Ensure that any protected property (or interest in) is not disposed of without the consent of MonitorNHS Improvement • Ensure that conflicts of interest are avoided • Ensure that <u>in the consideration of policy proposals relating to the expenditure</u>, relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account and brought to the attention of the Board of Directors

REF	DELEGATED TO	DUTIES DELEGATED
10	CHIEF EXECUTIVE	Ensure that effective management systems appropriate for the achievement of the NHS Foundation Trust's objectives, including financial monitoring and control systems, have been put in place.
11	CHIEF EXECUTIVE	Make sure that their arrangements for delegation -promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the <i>Public Sector Internal Audit Standards</i>
12 & 13 (see also 14 & 15)	CHIEF EXECUTIVE	<p>An Accounting Officer has particular responsibility to see that appropriate advice is tendered to the Board of Directors and the Council of Governors on all matters of financial propriety and regularity and, more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. Accounting Officers will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to their own duty as Accounting Officer to justify, to the Public Accounts Committee, transactions for which they are accountable.</p> <p>The Board of Directors and the Council of Governors of an NHS Foundation Trust should act in accordance with the requirements of propriety and regularity. If the Board of Directors, Council of Governors or the Chairman is contemplating a course of action involving a transaction which the accounting officer considers would infringe these requirements, they should set out in writing their objection to the proposal and the reasons for this objection. If the Board of Directors, Council of Governors or Chairman decides to proceed, they should seek a written instruction to take the action in question. They should also inform NHS ImprovementMonitor of the position, if possible before the decision is taken or in any event before the decision is implemented, so that NHS ImprovementMonitor, if it considers it appropriate, can intervene in accordance with its responsibilities under the Act.</p>
16 (see also 17-20)	CHIEF EXECUTIVE	The Comptroller and Auditor General may, under the National Audit Act 1983, carry out examinations into the economy, efficiency and effectiveness with which the NHS Foundation Trust has used its resources in discharging its functions. An Accounting Officer may expect to be called upon to appear before the Committee of Public Accounts Committee (PAC) from time to time to give evidence on the reports arising from these examinations or reports following the annual certification audit, and to answer the Public Accounts CommitteePAC's questions concerning expenditure and receipts for which he or she is accounting officer. An Accounting Officer may be supported by one or two other senior officials who may, if necessary assist in giving evidence.
21	CHIEF EXECUTIVE	Ensure that he or she is generally available for consultation and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a Deputy Chief Executive, appointed by the Chief Executive, in the NHS Foundation Trust who can act on his or her behalf if required.
22	BOARD OF DIRECTORS	If it becomes clear to the Board of Directors that an Accounting Officer is so incapacitated that he or she will be unable to discharge these responsibilities over a period of four weeks or more, the Board of

REF	DELEGATED TO	DUTIES DELEGATED
		Directors should appoint an Accounting Officer, usually the Director of Finance, pending the Accounting Officer's return. The same applies if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which he or she cannot be contacted.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY AND NHS FOUNDATION TRUST CODE OF GOVERNANCE

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
<p><u>NHS Foundation Trust Code of Governance A.1.9</u></p> <p>NHS Code of Conduct and Accountability April 1994 (revised 2004)</p>	ALL BOARD MEMBERS	Subscribe to Code of Conduct.
<p><u>NHS Foundation Trust Code of Governance</u></p> <p>NHS Code of Conduct and Accountability April 1994 (revised 2004)</p>	BOARD	Board members share corporate responsibility for all decisions of the Board.
<p>NHS Foundation Trust Code of Governance A.1</p>	BOARD	<p>Every NHS Foundation Trust should be headed by an effective Board of Directors, since the Board is collectively responsible for the exercise of powers and the performance of the NHS Foundation Trust:</p> <p>Supporting principles:</p> <ol style="list-style-type: none"> 1. The Board of Directors' role is to provide entrepreneurialactive leadership of the NHS Foundation Trust within a framework of prudent and effective controls which enables risk to be assessed and managed; 2. The Board of Directors is responsible for ensuring compliance by the NHS Foundation Trust with its Licence, its Constitution, mandatory guidance issued by MonitorNHS Improvement, relevant statutory requirements and contractual obligations; 2-3. The Board of Directors should develop and articulate a clear "vision" for the Trust. This

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		<p><u>should be a formally agreed statement of the organisation's purpose and intended outcomes which can be used as a basis for the organisation's overall strategy, planning and other decisions.</u></p> <p>3.4. The Board of Directors should set out the NHS Ffoundation Ttrust's strategic aims, taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place for the NHS Ffoundation Ttrust to meet its <u>priorities and objectives and, then, periodically-and reviewing progress and</u> management performance;</p> <p><u>5.</u> The Board of Directors as a whole is responsible for ensuring the quality and safety of healthcare services, education, training and research delivered by the NHS Ffoundation Ttrust and applying the principles and standards of clinical governance set out by the Department of Health, <u>NHS England, the</u> Care Quality Commission and other relevant NHS bodies.</p> <p>4.6. The Board of Directors should also ensure that the NHS Ffoundation Ttrust exercises its functions effectively, efficiently and economically; and</p> <p>5.7. The Board of Directors should set the NHS Ffoundation Ttrust's values and standards of conduct and ensure that its obligations to its members, patients and other stakeholders are understood and met.</p>
<p>Standing Order 2.6 (5)</p> <p>NHS Code of Conduct and Accountability April 1994 (revised 2004)</p>	CHAIRMAN	<p>It is the Chairman's role to:</p> <ol style="list-style-type: none"> 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration <u>and Nominations</u> Committee of the main-Board <u>of Directors</u> on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main-Board <u>of Directors</u>; <u>7.</u> appraise Non Executive Board Members in conjunction with the Council of Governors 7.
<p>Standing Order 2.6 (2)</p> <p>NHS Code of Conduct and</p>	CHIEF EXECUTIVE	<p>The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in</p>

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
Accountability April 1994 (revised 2004)		fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum (Monitor: April 2008) .
Standing Order 6.1 NHS Code of Conduct and Accountability April 1994 (revised 2004)	CHAIR AND DIRECTORS	Declaration of conflict of interests.

SCHEME OF DELEGATION FROM HARROGATE AND DISTRICT NHS FOUNDATION TRUST STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	CHAIRMAN	Final authority in interpretation of Standing Orders (SOs).
3.54	CHAIRMAN	Call meetings.
3.124	CHAIRMAN	Chair all Board meetings and associated responsibilities.
3.198	CHAIRMAN	Give final ruling in questions of order, relevancy and regularity of meetings.
3.2049	CHAIRMAN	Having a second or casting vote
3.298	BOARD	Suspension of Standing Orders
3.332	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.343	BOARD	Variation or amendment of Standing Orders
4.3	BOARD	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Chief Executive.)
4.2	CHAIRMAN & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
4.5	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of <u>Reservation and</u> Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
12.4	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
6.1	THE BOARD	Declare relevant and material interests.
6.4 & 8.3	CHIEF EXECUTIVE AND DEPUTY DIRECTOR OF CORPORATE AFFAIRS COMPANY SECRETARY	Maintain Register(s) of Interests.
8.1	ALL STAFF	Comply with national guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff". <u>the</u>

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		<u>Trust's Conflicts of Interest Policy.</u>
8.7	ALL	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
10.1	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
11.1	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

Date of Meeting:	25 July 2018	Agenda item:	5.3								
Report to:	Board of Directors										
Title:	Dispute Resolution Procedure for disputes between the Board of Directors and Council of Governors										
Sponsoring Director:	Mrs Angela Schofield, Chairman Dr Ros Tolcher, Chief Executive										
Author(s):	Mrs Katherine Roberts, Company Secretary										
Report Purpose:	<table border="1"> <tr> <td>Decision</td><td>✓</td><td>Discussion/ Consultation</td><td></td><td>Assurance</td><td></td><td>Information</td><td></td></tr> </table>			Decision	✓	Discussion/ Consultation		Assurance		Information	
Decision	✓	Discussion/ Consultation		Assurance		Information					
Executive Summary:	<ul style="list-style-type: none"> The Trust is required to 'comply or explain' with the Code of Governance for NHS Foundation Trusts. The Company Secretary prepares an annual assessment against the Code which is reported to the Audit Committee and is summarised in the Trust's Annual Report. During the review in May 2018 the '<i>Dispute Resolution Procedure for disputes between the Board of Directors and Council of Governors</i>' was identified as in place, but due for review. An updated version of the dispute resolution procedure is presented for comment and approval by the Board, prior to presentation to the Council of Governors in August 2018. 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td><td>✓</td><td>To work with partners to deliver integrated care:</td><td>✓</td><td>To ensure clinical and financial sustainability:</td><td>✓</td></tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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 Trust is required to 'comply or explain' with the Code of Governance for NHS Foundation Trusts. The <i>Dispute Resolution Procedure for disputes between the Board of Directors and Council of Governors</i> is a key document in achieving compliance with the Code.										
Resource:	None identified.										
Impact Assessment:	Not applicable.										
Conflicts of Interest:	None identified.										
Reference documents:	NHS Foundation Trust Code of Governance: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/327068/CodeofGovernanceJuly2014.pdf										
Assurance:	Not applicable, this matter is reserved to the Board.										

Action Required by the Board of Directors:

It is recommended that the Board approves the *Dispute Resolution Procedure for disputes between the Board of Directors and Council of Governors* and recommends the procedure to the Council of Governors for approval in August 2018.

Dispute Resolution Procedure for disputes between the Board of Directors and Council of Governors

1.0 Introduction

1.1 The Foundation Trust Code of Governance requires the Trust to hold a clear statement explaining how disagreements and disputes between the Council of Governors and the Board of Directors would be resolved.

1.2 The Board of Directors, through the Chairman and Chief Executive, promotes effective communications between the Council of Governors and the Board of Directors.

1.3 In all cases all members of the Board of Directors and the Council of Governors should attempt to negotiate a settlement in good faith.

2.0 Informal dispute resolution

2.1 Initially informal mechanisms would be pursued to resolve any disputes between the Board of Directors and the Council of Governors.

2.2 The matter would initially be referred to the Chairman of the Trust who would attempt to seek a resolution with the support of the Company Secretary.

2.3 In the event that this is not successful the Chairman would engage the support of the Senior Independent Director and the Deputy Chairman of Governors who would jointly attempt to resolve the dispute, discussing outcomes openly with the Board of Directors and Council of Governors to reach a joint solution.

3.0 Formal dispute resolution procedure

3.1 Where such a dispute, between the Board of Directors and the Council of Governors, is in relation to law, power or authority of one of the parties and cannot be resolved in accordance with the informal dispute resolution procedure referred to in section 2.0, the dispute may be referred to mediation in accordance with section 3.2.

3.2 The procedure for any such mediation shall be as follows:

3.2.1 A neutral person, being an accredited (with either the Law Society or the Civil Mediation Council) mediator, (the "Mediator") shall be chosen by agreement between the two parties. Alternatively, either party may within seven days from the date of the proposal to appoint a mediator, or within seven days of notice to any party that the chosen mediator is unable and unwilling to act, apply to the Centre for Dispute Resolution ("CEDR") to appoint a Mediator.

3.2.2 The parties shall within seven days of the appointment of the Mediator agree a timetable for the exchange of all relevant and necessary information and the procedure to be adopted for the mediation. If appropriate, the parties may at any stage seek from CEDR guidance on a suitable procedure.

3.2.3 All negotiations and proceedings in the mediation connected with the dispute shall be conducted in strict confidence and shall be without prejudice to the rights of the parties in any future proceedings.

3.2.4 All information (whether oral or in the form of documents, tapes, computer disks etc) produced for, during, or as a result of, the mediation will be without prejudice, privileged and not admissible as evidence or discoverable in any litigation or arbitration relating to the dispute. This does not apply to any information which would in any event have been admissible or discoverable in any such litigation or arbitration.

3.2.5 The Mediator's reasonable fees and other expenses of the mediation will be borne by the Foundation Trust. The Foundation Trust will bear the reasonable costs and expenses of the participation in the mediation.

3.2.6 If the parties reach agreement on the resolution of the dispute that agreement shall be reduced to writing and shall be binding upon the relevant parties.

3.2.7 For a period of ninety days from the date of the appointment of the Mediator, or such other period as the parties may agree, neither party may commence any proceedings in relation to the matters referred to the Mediator.

3.2.8 If the parties are unable to reach a settlement at the mediation and only if both parties so request and the Mediator agrees, the Mediator will produce for the parties a non-binding recommendation on terms of settlement. This will not attempt to anticipate what a court might order but will set out what the Mediator suggests are appropriate settlement terms in all of the circumstances. Such opinion shall be provided on a without prejudice basis.

3.2.9 Subject to Conditions 3.2.6 and 3.2.7, should either party decide to pursue the dispute in a court, the Foundation Trust shall not be liable for any of the costs or expenses in relation to such proceedings.

4.0 This procedure does not restrict a governor's right to act under Section 14 of the Constitution. Extract from the Harrogate and District NHS Foundation Trust 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 voting approve the referral.*

Date of Meeting:	25 July 2018	Agenda item:	5.4								
Report to:	Board of Directors										
Title:	Alteration to the Accounting Reference Date for Harrogate Healthcare Facilities Management Limited (HHFM)										
Sponsoring Director:	Not applicable.										
Author(s):	Mrs Katherine Roberts, Company Secretary (for the Trust and HHFM)										
Report Purpose:	<table border="1"> <tr> <td>Decision</td> <td>✓</td> <td>Discussion/ Consultation</td> <td></td> <td>Assurance</td> <td></td> <td>Information</td> <td></td> </tr> </table>			Decision	✓	Discussion/ Consultation		Assurance		Information	
Decision	✓	Discussion/ Consultation		Assurance		Information					
Executive Summary:	<ul style="list-style-type: none"> The Trust has a wholly owned subsidiary company; Harrogate Healthcare Facilities Management Limited (HHFM). In establishing this company the Trust reserved a number of matters to the Trust Board of Directors. One of these is the power to alter the Company's accounting reference date. The Board of HHFM have considered, and present for approval a proposal that the company's accounting reference date is altered from 30 November (date the company was established) to 31 March. Altering the accounting reference date to 31 March would bring the company's accounting cycle in line with the Trust and would be helpful to the process of preparing the Trust's consolidated accounts (which will include HHFM). 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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 power to alter the Company's accounting reference date is reserved to the Trust's Board of Directors, as the company's sole shareholder.										
Resource:	None identified.										
Impact Assessment:	Not applicable.										
Conflicts of Interest:	As directors of HHFM, Mr Coulter and Mr Thompson have a potential perceived conflict of interest in this agenda item.										

	It is recommended that the Board give permission for Mr Coulter and Mr Thompson to remain and participate in this agenda item.
Reference documents:	The Articles of Association of HHFM (which detail the reserved powers) is available on request.
Assurance:	<p>Not applicable, this matter is reserved to the Board of Directors. The Board of HHFM considered this matter in June 2018 and agreed to present the proposal to the Trust Board of Directors for approval.</p> <p>KPMG the Trust and HHFM's auditors have reviewed and confirmed support for the technical accounting content of this report.</p>
Action Required by the Board of Directors:	
It is recommended that the Board approves the recommendation from the Board of Harrogate Healthcare Facilities Management Limited, that the accounting reference date of the company is altered from 30 November to 31 March.	

Date of Meeting:	25 July 2018	Agenda item:	6.0a								
Report to:	Board of Directors										
Title:	Report from the Chief Executive										
Sponsoring Director:	Dr Ros Tolcher, Chief Executive										
Author(s):	Dr Ros Tolcher, Chief Executive										
Report Purpose:	<table border="1"> <tr> <td>Decision</td><td></td><td>Discussion/ Consultation</td><td>✓</td><td>Assurance</td><td>✓</td><td>Information</td><td>✓</td></tr> </table>			Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<ul style="list-style-type: none"> Financial performance remains extremely challenging. The Trust reported an in month deficit of £869k which represents an adverse variance of £1.3m. The year to date position is therefore a deficit of £3.2m. The Trust met all cancer pathway standards including the 14 day symptomatic breast patients in June. RTT continues to improve but remains below the 92% standard. Emergency department attendances were 9.5% above plan in June; the A&E 4 hour standard was however met for 94.9% of patients. The Trusts Vision, Mission, Values and Strategic Objectives have been updated and are presented for adoption. The NHS70 celebrations were wholly embraced by staff and attracted very positive media coverage. 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td><td>✓</td><td>To work with partners to deliver integrated care:</td><td>✓</td><td>To ensure clinical and financial sustainability:</td><td>✓</td></tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓						
Key implications											
Risk Assessment:	Strategic and operational risks are noted in section 7. Risks associated with this report are reflected in the Board Assurance Framework: BAF 14: risk to deliver of integrated models of care; BAF 15: misalignment of partner strategic plans; and BAF 9; failure to deliver the operational plan.										
Legal / regulatory:	There are no legal/regulatory implications highlighted within the report.										
Resource:	There are no resource implications highlighted within the report.										
Impact Assessment	Not applicable.										
Conflicts of Interest:	None identified.										
Reference documents:	Care Quality Commission report: 'Beyond Barriers: how older people move between health and care in England' https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england										
Assurance:	Not applicable.										
Action Required by the Board of Directors:											
<ul style="list-style-type: none"> The Board is asked to note progress on risks recorded in the BAF and Corporate Risk Register and confirm that progress reflects the current risk appetite. 											

- The Board is requested to **endorse** use of the Trust's seal and agreement of a license as detailed in the report.
- The Board is asked to **approve** and adopt the updated suite of Vision, Mission, and Values, objectives and goals statement.

1.0 MATTERS RELATING TO QUALITY, PATIENT EXPERIENCE AND PERFORMANCE

1.1 Operational Performance (details contained within the Integrated Board Report)

Levels of non-elective admissions have settled to a more seasonal norm during month 3 allowing bed occupancy to improve. High rates of emergency department attendances (9.5% above plan in June) however are impacting on the Trust's ability to meet the A&E 4 hour standard which was marginally below the required level in June achieving 94.9%. The Trust met all cancer pathway standards in month; including 14 day maximum wait for symptomatic breast patients which has recovered to 95.8%.

Key indicators of care quality for the month show a positive and improving position; the overall Patient Safety Thermometer score shows that 96.1% of people experienced harm-free care, an improvement which reflects lower rates of pressure ulcers and falls compared to recent months.

Data for the whole of Quarter 1 shows that the Trust performance was below the required level for three of the four key operational metrics. The Trust achieved all cancer pathway targets with the exception of the 2 week wait for symptomatic breast patients; for 18 week RTT we achieved 90.8% against the 92% standard and for the A&E 4 hour standard the quarter 1 performance was 94.8% against the 95% standard. In the context of ongoing workforce and capacity challenges sustaining strong operational performance will remain a significant challenge for us in to quarter two and beyond.

NHSI has launched a 'long stays dashboard' which captures daily and monthly data on bed use for people with stays greater than 7 and 21 days alongside a subset of other key performance metrics impacting on safety and flow, including DTOCs (delayed transfers of care) and the A&E 4 hour standard.

2.0 FINANCIAL POSITION

2.1 Financial performance

The Trust reported a deficit for the month of June of £869k which represents an in month adverse variance of £1.3m against the Trust's internal plan. The year to date position is therefore a deficit of £3.2m which represents an adverse variance to the internal plan of £2.6m.

As in previous months, the main drivers of the deficit run rate are the additional costs of bank, agency and locum staffing, and some shortfall in CIP attainment. A shortfall in community income is also recorded. Work to reduce pay overspends remains a significant focus. Following tightened controls on above establishment staffing there has been in-month a 37% reduction in the ward pay overspending; agency staffing overall also improved significantly in month, falling to 2.63% of the overall pay bill. A step change in ward expenditure is required in order to correct this position.

The adverse performance on the internal plan is a significant concern and further measures will be required to recover this position. Financial performance does however remain ahead of the plan agreed with NHS Improvement as we are therefore able to continue to report full achievement of Provider Sustainability Funding in respect of financial performance for Quarter 1.

The Trust reported a rating of 3 in June, in line with the annual plan submitted to NHS Improvement. Further details are contained in the Finance Director's report.

2.2 NHSI Diagnostic

A draft report has been received from NHS Improvement, to be followed up with a meeting later this month. The report contains some suggestions which will now be explored in more detail.

3.0 STRATEGIC UPDATE

3.1 This is Us: HDFT Vision, Mission, Values and Objectives

Following review at the June Board Strategy day two changes have been made to the description of the Trust's key statements on vision, mission and objectives. The review recognised the broad portfolio of services provided by the Trust and in particular its Public Health services to children and families commissioned by Local Authorities. The board agreed that 'people we serve' should replace 'patients' in our annual goals statement, as this more accurately describes our full range of services. Secondly, the word 'care' has been replaced with 'healthcare' in our first strategic objective.

The Board of Directors is asked to formally adopt the Trusts statements, copied below.



3.2 West Yorkshire and Harrogate Health Integrated Care System (ICS)

Following the announcement in June 2018 that WY&H HCP had been named as one of four areas joining the new Integrated Care System programme, the System Leadership Group have been considering how funding to support transformation will best be deployed to enable service innovation and sustain strong performance. There is a shared ambition to prioritise improvements in urgent and emergency care and achieve sustained, system level improvement in the A&E 4-hour standard in particular. An element of the funding is also earmarked for Primary Care Development.

Positive progress on the ICS Memorandum of Understanding continues and is on plan for sign off in September.

4.0 WORKING IN PARTNERSHIP

4.1 Harrogate System Leadership Executive Group

There has been no meeting of the HSLG since the last report to the Board of Directors. Positive progress continues in the HSLG subgroups.

5.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 18th July 2018. The following key areas are for noting:

- There have been no grade three or four pressure ulcers on any medical wards for more than four months. This follows the introduction of a revised approach to care.
- Drivers of the adverse financial run rate were explored in detail. Some specific work with ward managers designed to align expenditure to establishments was agreed.
- Detailed scrutiny by the savings delivery and oversight group has resulted in some adjustments to CIP plans and a higher level of assurance on feasibility. Gaps in central and corporate schemes are now being addressed.
- A revised approach to Directors Inspection and Safety Visits was agreed for recommendation to the Board.
- Noted that meeting the Cancer 62-day pathway standard has been challenging and the impact of this on inter-provider transfers. An element of national Cancer Alliance funding is predicated on system performance and the Trust is working closely with partners to address this risk.

6.0 COMMUNICATIONS RECEIVED AND ACTED UPON

6.1 Yorkshire and Humber – Local Health and Care Record Exemplar

Yorkshire and Humber has been successful in its bid to become a Local Health and Care Record Exemplar (LHCRE). This is a new partnership intended to provide health and care staff with better and faster access to vital information about the person in their care and is being established across the Yorkshire and Humber region. The partnership will use technology and digital innovations to link systems across health and care organisations, enabling care providers to work more closely together. It will result in the creation of a new Yorkshire & Humber Care Record, which will also provide citizens with access to their information and encourage them to be more involved in looking after their health.

As a result of being accepted as one of five LHCREs, the partnership will receive up to £7.5 million over two years to put in place an electronic shared local health and care record that makes the relevant information about people instantly available to everyone involved in their care and support.

6.2 Agenda for Change Pay Deal 2018/19

The Department for Health and Social Care (DHSC) has provided Guidance on the Agenda for Change pay deal for 2018/19 and the Trust has received an initial indication of the funds to be transferred to cover the cost of implementing the uplifts. Of relevance to HDFT, the guidance confirms:

- The funding calculation for 2018/2019 will be based on staff in post and bank staff up to 31/03/2018. The calculation will not include vacancies.
- The methodology is based on 2018/19 financial plans and electronic staff record (ESR) data.
- Wholly owned subsidiaries (WOSs): the guidance states the current methodology may over-compensate some providers, and gives the example of WOSs where staff are paid via ESR but are not employed on the AfC contract.

DHSC will confirm “in due course” how funding will be made available from 2019/20.

6.3 New Secretary of State for Health and Social Care

The Rt Hon Matt Hancock MP has been appointed as Secretary of State for Health and Social Care. Prior to his appointment, Mr Hancock was Secretary of State for Digital, Culture, Media and Sport. Before becoming an MP, he worked as an advisor for then Shadow Chancellor, George Osborne, later becoming his chief of staff. Digital technology is a key focus for Mr Hancock, having launched his own social media app to connect with his constituents.

He now oversees the ministerial team put in place in January:

- Stephen Barclay MP, Minister of State for Health
- Caroline Dinenage MP, Minister of State for Care
- Lord O'Shaughnessy, Parliamentary Under-secretary of State (Lords)
- Steve Brine MP, Parliamentary Under-secretary of State for Public Health and Primary Care
- Jackie Doyle-Price MP, Parliamentary Undersecretary of state for Mental Health and Inequalities

6.4 Care Quality Commission report: ‘Beyond Barriers: how older people move between health and care in England’

In early July 2018 the Care Quality Commission (CQC) published a report summarising the CQC’s findings following a programme of targeted local system reviews.

The CQC found that:

- Organisations intended to work together but mostly focused on their own goals.
- Although there was good planning between services, the way services were funded did not support them to work together.
- The regulatory framework focuses only on individual organisations.
- Organisations:
 - were prioritising their own goals over shared responsibility to provide person centred care

- did not always share information with each other which meant they weren't able to make informed decisions about people's care
- were not prioritising services which keep people well at home
- planned their workforce in isolation to other services.

Their recommendations were:

1. Reform of planning and commissioning of services. An agreed joint plan, funded in the right way, should support older people in their own homes, help them in an emergency, and then to return home safely.
2. A new approach to system performance management. This would measure how organisations collectively deliver improved outcomes for older people.
3. Joint workforce planning. This would allow flexible and collaborative approaches to staff skills and career paths.
4. Better oversight of local system performance. New legislation so CQC could regulate how people and organisations work together to support people to stay well.

7.0 BOARD ASSURANCE AND CORPORATE RISK

7.1 Board Assurance Framework (BAF)

No new risks have been added to the BAF this month. Six risks (an improvement on five in June 2018) are currently assessed as having achieved their target risk score. The strategic risks are as summarized as follows:

Ref	Description	Risk score	Progress score	Target risk score reached
BAF 1	Risk of a lack of medical, nursing and clinical staff	Red 12 ↔	Unchanged at 1	
BAF 2	Risk of a high level of frailty in the local population	Amber 8 ↔	Unchanged at 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	Amber 8 ↔	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	Red 12 ↑	Unchanged at 1	

7.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 13 July 2018. The Corporate Risk Register contains 11 risks.

Corporate Risk Register Summary

Corporate risk register summary of changes: Updated July 2018						
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 following the Deanery allocation process	12	↔	2	Mar-19	
CR5	Risk to service delivery due gaps in registered nurses establishment	12	↔	2	Mar-19	
CR13	Capacity to support timely discharge for community ready patients	12	↔	2	Mar-19	
CR14	Risk of financial deficit and impact on service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income.	12	↔	2	Mar-19	
CR17a	Risk of patient harm as a result of being lost to follow-up as a result of current processes	12	↔	3	Sep-18	
CR17b	Risk of patient harm as a result of being lost to follow up as a result of historic processes	12	↔	3	Dec-18	
CR18	Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down	12	↔	4	Mar-19	
CR24	Risk to patient safety, quality, experience, reputation, staff wellbeing due to reduced capacity in the Community Care teams (CCTs).	12	↔	3	Mar-19	
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	↔	3	Nov-18	Target score increased to C3 x L2 = 6
CR27	Risk to service delivery due to failure to have sufficient cash to support the capital programme including replacement of equipment due to delay in payment from commissioners or shortfall in delivering the financial plan	12	↔	2	Apr-19	
CR29	Risk to patient safety, quality of care, patient experience and privacy and dignity due to environmental factors on CATT Ward and Clinic. Environment also impacting on recruitment and retention	12	New	2	Sep-19	

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

8.0 DOCUMENTS SIGNED AND SEALED

The following documents have been sealed during the month:

- 7 year leases, with appropriate break clauses, for offices at Camberwell Way in Sunderland.
- 24 month lease for offices at Tyne View.

In addition the following documents have been signed during the month:

- 6 month licence for Tyne View (Gateshead) Records Storage and Scanning space.
- 6 month licence for Civic Centre (Gateshead) Records Storage and Scanning space.
- 24 month lease for offices at Civic Centre.
- Agreement for lease for works undertaken at Camberwell Way.

- 3 year licence for shuttle bus and car parking services to service Camberwell Way.

It should be noted that all the above legal matters are in relation to the Trust winning the 0-19 Children's Services contracts in Gateshead and Sunderland, with service contracts having commenced on 1 July 2018.

Dr Ros Tolcher
Chief Executive
18 July 2018

Date of Meeting:	25 July 2018	Agenda item:	6.0b								
Report to:	Board of Directors										
Title:	Integrated Board Report										
Sponsoring Director:	Dr Ros Tolcher, Chief Executive										
Author(s):	Ms Rachel McDonald, Head of Performance & Analysis										
Report Purpose:	<table border="1"> <tr> <td>Decision</td><td></td><td>Discussion/ Consultation</td><td>✓</td><td>Assurance</td><td>✓</td><td>Information</td><td>✓</td></tr> </table>			Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<p>The Trust is required to report its operational performance to NHS Improvement and to routinely submit performance data to NHS England and Harrogate and Rural District CCG. The Board of Directors are asked to note that:</p> <ul style="list-style-type: none"> The Trust reported a deficit position of £869k in June, significantly behind the in month plan and control total plan. This results in a year to date position of £3.2m deficit. This is significantly behind the Trust's internal plan deficit for Quarter 1 of £631k. Agency expenditure reduced in June but the year to date position remains high with 3.7% of pay expenditure relating to agency staffing. Staff sickness absence has reduced for the fourth successive month and is now just above the local threshold of 3.9%. HDFT's performance against A&E 4-hour standard was below 95% in June and for Quarter 1 overall. The Trust's 18 weeks performance remained below the 92% standard in June resulting in an overall performance for Quarter 1 of 90.8%. All cancer waiting times standards were achieved for Quarter 1, with the exception of the 2 week wait cancer waiting times standard for breast symptomatic patients which showed improvement in June but remained below the 93% standard for Quarter 1 overall. June's safety thermometer results showed that 96.1% of patient surveyed were harm free, a significant improvement on recent months. However the harm free percentage for the community teams remains below 95% at 94.0%. 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td><td>✓</td><td>To work with partners to deliver integrated care:</td><td>✓</td><td>To ensure clinical and financial sustainability:</td><td>✓</td></tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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 4: risk of a lack of interoperable systems across New Care Models partners; BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence; BAF 16: risk to delivery of integrated care models.										
Legal / regulatory:	None identified.										
Resource:	Not applicable.										
Impact Assessment:	Not applicable.										

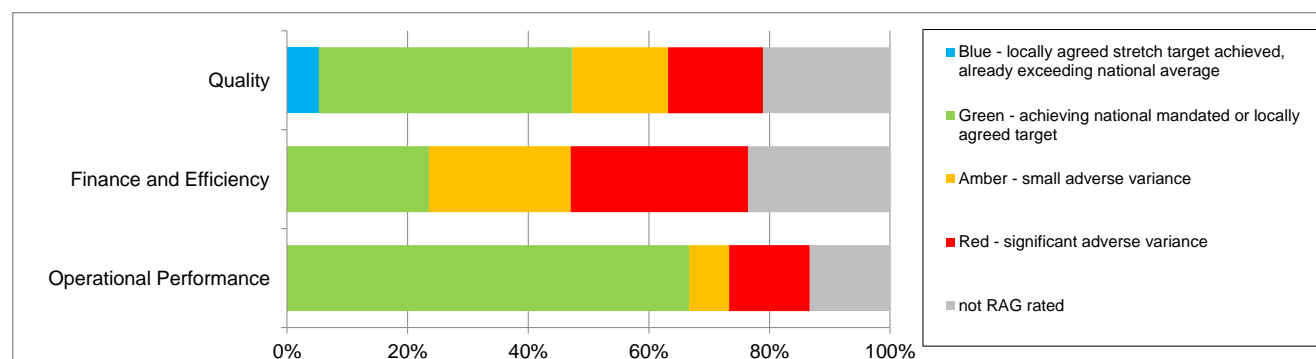
Conflicts of Interest:	None identified.
Reference documents:	None.
Assurance:	Report reviewed monthly at Senior Management Team in Operational Delivery Group.
Action Required by the Board of Directors:	
The Board of Directors are asked to receive and note the content of the report.	

Integrated board report - June 2018

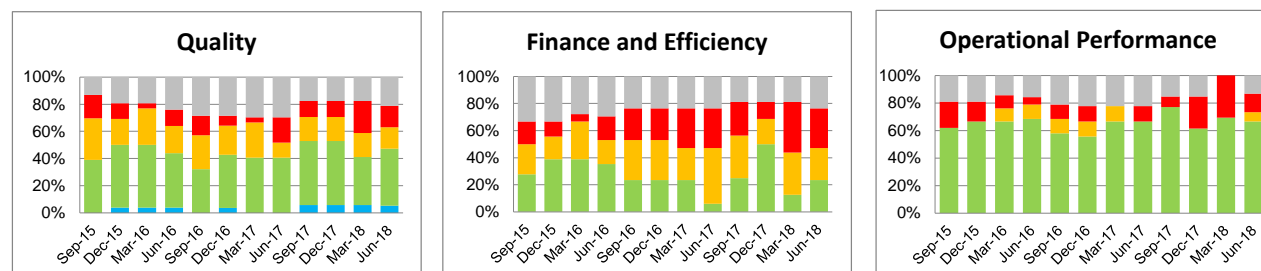
Key points this month

1. The Trust reported a deficit position of £869k in June, significantly behind the in month plan and control total plan. This results in a year to date position of £3.2m deficit. This is significantly behind the Trust's internal plan deficit for Quarter 1 of £631k.
2. Agency expenditure reduced in June but the year to date position remains high with 3.7% of pay expenditure relating to agency staffing.
3. Staff sickness absence has reduced for the fourth successive month and is now just above the local threshold of 3.9%.
4. HDFT's performance against A&E 4-hour standard was below 95% in June and for Quarter 1 overall.
5. The Trust's 18 weeks performance remained below the 92% standard in June resulting in an overall performance for Quarter 1 of 90.8%.
6. All cancer waiting times standards were achieved for Quarter 1, with the exception of the 2 week wait cancer waiting times standard for breast symptomatic patients which showed improvement in June but remained below the 93% standard for Quarter 1 overall.
7. June's safety thermometer results showed that 96.1% of patient surveyed were harm free, a significant improvement on recent months. However the harm free percentage for the community teams remains below 95% at 94.0%.

Summary of indicators - current month



Summary of indicators - recent trends



Quality - June 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<div> </div> <p>Pressure ulcers - hospital acquired</p>	<p>The chart shows the cumulative number of 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.</p>		<p>There were 4 hospital acquired unstageable or category 3 pressure ulcers reported in June, bringing the year to date total to 9. This compares to an average of 5 per month reported in 2017/18.</p> <p>For the 9 cases reported in 2018/19 to date, 2 have been assessed as avoidable, 3 as unavoidable and 4 are still under root cause analysis (RCA). No category 4 hospital acquired pressure ulcers have been reported in 2018/19 to date.</p>
	<p>The chart includes category 2, 3 and 4 and unstageable hospital acquired pressure ulcers. The data includes hospital teams only.</p>		<p>The number of hospital acquired category 2-4 (or unstageable) pressure ulcers reported in June was 16, a decrease on last month and below the average per month reported in 2017/18.</p>
<div> </div> <p>Pressure ulcers - community acquired</p>	<p>The chart shows the cumulative number of 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.</p>		<p>There were 9 community acquired unstageable or category 3 pressure ulcers reported in June, compared to 5 last month. The average per month reported in 2017/18 was 12.</p> <p>For the 21 cases reported in 2018/19 to date, 0 have been assessed as avoidable, 15 as unavoidable and 6 are still under root cause analysis (RCA).</p>
	<p>The chart includes category 2, 3 and 4 and unstageable community acquired pressure ulcers. The data includes community teams only.</p>		<p>The number of community acquired category 2-4 (or unstageable) pressure ulcers reported in June was 29 cases, an increase on last month and above the average per month reported in 2017/18.</p>

Quality - June 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
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.		The harm free percentage for June was 96.1%, above 95% and a significant improvement on recent months.
Safety thermometer - harm free care Community Care Teams 	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. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.		<p>The harm free percentage for June was 94.0%, an improvement on last month but remaining below 95%.</p> <p>The majority of harms reported this month by the community teams relate to old pressure ulcer - these harms may have been acquired prior to the patient being first seen by the community teams, but are still reportable as harms based on the nationally defined reporting requirements.</p>
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.		The rate of inpatient falls was 5.41 per 1,000 bed days in June, a further decrease and below the average HDFT rate for 2017/18. There was 1 fall resulting in a fracture in June (3 last month).
Infection control 	The chart shows the cumulative number of hospital apportioned C. difficile cases during 2018/19. HDFT's C. difficile trajectory for 2018/19 is 11 cases, a reduction of 1 on last year's trajectory. 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 2018/19. The last reported case of hospital acquired MRSA at HDFT was in Oct-12.		<p>There was 1 case of hospital apportioned C. difficile reported in June, bringing the year to date total to 3. 1 of the 3 cases has had root cause analysis completed and agreed with HARD CCG. The outcome was that no lapse of care had occurred. 2 cases are still under root cause analysis.</p> <p>No hospital apportioned MRSA cases have been reported in 2018/19 to date.</p>

Quality - June 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Avoidable admissions 	<p>The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.</p>		<p>Provisional data indicates that there were 262 avoidable admissions in May, an increase on last month but remaining below previous months. However this month's figure is above the level reported in May last year (204).</p> <p>Adult avoidable admissions (excluding CAT attendances) remain in line with last month.</p>
Mortality - HSMR 	<p>The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.</p>		<p>HDFT's HSMR for the rolling 12 months ending March 2018 was 104.8, a decrease on last month and remaining within expected levels. At specialty level, 2 specialties have a higher than expected standardised mortality rate (Geriatric Medicine and Trauma & Orthopaedics).</p>
Mortality - SHMI 	<p>The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.</p>		<p><i>There is no update of this data available this month due to a delay in the data being released by NHS Digital.</i></p> <p>HDFT's SHMI increased to 89.1 for the rolling 12 months ending December 2017 but remains below expected levels.</p> <p>At specialty level, four specialties (Respiratory Medicine, Gastroenterology, Geriatric Medicine and one small volume surgical specialty) continue to have a standardised mortality rate above expected levels.</p>
Complaints 	<p>The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.</p>		<p>13 complaints were received in June, a reduction on last month and below the average for 2017/18. No complaints were classified as amber or red this month. The complaints received this month are in relation to a number of different HDFT services.</p>

Quality - June 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Incidents - all 	<p>The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services.</p> <p>A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture</p>		<p>The latest published national data (for the period Apr - Sep 17) shows that Acute Trusts reported an average ratio of 44 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 26, a minor improvement on the last publication but remaining in the bottom 25% of Trusts nationally. HDFT's latest local data gives a ratio of 15, a deterioration on this position. The focus going forward is to improve our incident reporting rate particularly encouraging staff to report no harm/ near miss incidents. Options to improve the Datix system to simplify the incident reporting process are being explored.</p>
Incidents - SIRIs and never events 	<p>The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services.</p> <p>Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the pressure ulcer / falls indicators above.</p>		<p>There were 1 comprehensive SIRI reported in June. No Never Events were reported in 2017/18 or in 2018/19 to date.</p>
Friends & Family Test (FFT) - Patients 	<p>The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.</p>		<p>94.8% of patients surveyed in June would recommend our services, a reduction on recent months but remaining above the latest published national average (93.7%). The inpatient, day case, outpatient and community service surveys all saw minor reductions in the % recommending. A&E and maternity services saw an increase in % recommending.</p> <p>Around 4,900 patients responded to the survey this month. The issue with the automated phone call surveys has now been resolved and the number of responses is in line with historical averages.</p>
Friends & Family Test (FFT) - Adult community services 	<p>The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of adult community services including specialist nursing teams, community care teams, community podiatry and GP OOH. A high percentage is good.</p>		<p>92.9% of patients surveyed in June would recommend our services, a reduction on recent months. 420 patients from adult community services responded to the survey this month. The data for March 2018 is not included as there were very few responses from community services due to an issue with the automated phone call surveys which was rectified in mid-April.</p>

Quality - June 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation																
<div>Safer staffing levels</div> <div></div>	Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website.		Overall staffing compared to planned was at 102% in June, no change on last month and remaining above 100%. Care Support Worker staffing remains high compared to plan - this is reflective of the increased need for 1-1 care. Whilst safer staffing levels for registered nurses remains below 100%, the staffing level achieved still enables the delivery of safe care. Achieving safe staffing levels remains challenging and requires the increasing use of temporary staff through the nurse bank and agencies.																
<div>Staff appraisal rates</div> <div></div>	The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good.		Appraisal compliance continued to fall during the appraisal period and has been reported at 74.66% in June. HR Business Partners are following up with all Directorates in month to ensure that plans are in place to deliver appraisals within the appraisal window.																
<div>Mandatory training rates</div> <div></div>	The table shows the most recent training rates for all mandatory elements for substantive staff.	<table><thead><tr><th>Competence Name</th><th>% Completed</th></tr></thead><tbody><tr><td>Equality, Diversity and Human Rights - Level 1</td><td>90</td></tr><tr><td>Fire Safety Awareness</td><td>76</td></tr><tr><td>Infection Control - No Renewal</td><td>99</td></tr><tr><td>Infection Prevention & Control (Including Hand Hygiene) 2</td><td>82</td></tr><tr><td>Data Security Awareness</td><td>92</td></tr><tr><td>Safeguarding Children & Young People Level 1 - Introduction eLearning</td><td>94</td></tr><tr><td>Risk Awareness - No Renewal (Replaced Basic Risk Management May 2018)</td><td>97</td></tr></tbody></table>	Competence Name	% Completed	Equality, Diversity and Human Rights - Level 1	90	Fire Safety Awareness	76	Infection Control - No Renewal	99	Infection Prevention & Control (Including Hand Hygiene) 2	82	Data Security Awareness	92	Safeguarding Children & Young People Level 1 - Introduction eLearning	94	Risk Awareness - No Renewal (Replaced Basic Risk Management May 2018)	97	The data shown is for the end of June and excludes the Harrogate Healthcare Facilities Management (HHFM) staff who transferred into the new organisation on the 1st March 2018 and excludes Stockton staff who Tupe transferred in to the Trust on 1st April 2018. The overall training rate for mandatory elements for substantive staff is 90% and has decreased 1% since the last reporting cycle.
Competence Name	% Completed																		
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Risk Awareness - No Renewal (Replaced Basic Risk Management May 2018)	97																		
<div>Sickness rates</div> <div></div>	Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%. A low percentage is good.		Staff sickness absence continues to fall with June's data indicating 3.91% absence. Return to work compliance is increasing and is at 77% for the Trust. The Attendance Management lead continues to focus on those areas with higher level of sickness absence with specific focus on long term absences. A provisional position of June's data for sickness absence and labour turnover has been included in order to provide greater visibility of this data. June's data will be validated in August and on an on-going basis until we have assurance about reporting accuracy.																

Quality - June 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Staff turnover rate 	<p>The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust.</p> <p>Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.</p>	<p>Legend:</p> <ul style="list-style-type: none"> Involuntary Turnover % Voluntary Turnover % turnover norm 	<p>Labour turnover remains static at 12%. HR Business partners are reminding the managers of the importance of exit interview completion for identifying trends.</p> <p>A provisional position of June's data for sickness absence and labour turnover has been included in order to provide greater visibility of this data. June's data will be validated in August and on an on-going basis until we have assurance about reporting accuracy.</p>

Finance and Efficiency - June 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Readmissions 	<p>% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.</p>		<p>The number of emergency readmissions in May (after PbR exclusions are applied) was 257. This equates to 13.5% when expressed as a percentage of all emergency admissions, a small increase on last month and remaining just above the HDFT average rate for 2017/18.</p>
Length of stay - elective 	<p>Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.</p>		<p>HDFT's average elective length of stay for June was 2.2 days. This is a decrease on last month and places HDFT in the top 25% of Trusts nationally in the most recently available benchmarking data.</p> <p>There is no update of the benchmarking data this month. Two months' worth of data will be published on HED next month.</p>
Length of stay - non-elective 	<p>Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.</p>		<p>HDFT's average non-elective length of stay for June was 5.3 days, an increase on last month. The Trust remains in the middle 50% of Trusts nationally when compared to the most recently available benchmarking data.</p> <p>There is no update of the benchmarking data this month. Two months' worth of data will be published on HED next month.</p>
Theatre utilisation 	<p>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.</p> <p>A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.</p>		<p>Elective theatre utilisation was at 86.3% in June, remaining above the 85% optimal level. This utilisation only reflects the elective lists that took place as planned and does not factor in planned elective lists that were cancelled. A list cancellation metric is being incorporated into the new theatres dashboard and will be considered for inclusion in this report.</p>

Finance and Efficiency - June 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Delayed transfers of care 	<p>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.</p> <p>The maximum threshold shown on the chart (3.5%) has been agreed with HARD CCG.</p>		<p>In June, 4.5% of bed days were lost due to delayed transfers of care, a deterioration on last month and above the local standard of 3.5%.</p>
Outpatient DNA rate 	<p>Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance.</p> <p>A low percentage is good. Patient DNAs will usually result in an unused clinic slot.</p>		<p>There is no update of this indicator this month. Two months' worth of data will be published on HED next month.</p> <p>HDFT's DNA rate increased to 6.2% in March. This is in line with the benchmarked group of trusts and below the national average.</p>
Outpatient new to follow up ratio 	<p>The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.</p>		<p>There is no update of this indicator this month. Two months' worth of data will be published on HED next month.</p> <p>Reducing the number of follow ups is a major part of HARD CCG's financial recovery plan. HDFT's new to follow up ratio was 1.94 in March, an increase on last month but remaining below both the national and benchmark group average.</p>
Day case rate 	<p>The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight.</p> <p>A higher day case rate is preferable.</p>		<p>The day case rate was 89.7% in June, no change on last month and remaining above the average day case rate for 2017/18 (89.3%).</p>

NHS Foundation Trust																																																																											
Indicator name / data quality assessment	Description	Trend chart	Interpretation																																																																								
<div>Surplus / deficit and variance to plan</div> <div></div>	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.	<table><thead><tr><th>Month</th><th>Actual</th><th>Control total</th><th>Internal plan</th></tr></thead><tbody><tr><td>Apr-18</td><td>-£2,500</td><td>-£2,500</td><td>-£1,500</td></tr><tr><td>May-18</td><td>-£1,500</td><td>-£500</td><td>£500</td></tr><tr><td>Jun-18</td><td>-£1,000</td><td>£0</td><td>£500</td></tr><tr><td>Jul-18</td><td>£0</td><td>£500</td><td>£500</td></tr><tr><td>Aug-18</td><td>£0</td><td>-£500</td><td>£500</td></tr><tr><td>Sep-18</td><td>£0</td><td>£500</td><td>£500</td></tr><tr><td>Oct-18</td><td>£0</td><td>£1,500</td><td>£500</td></tr><tr><td>Nov-18</td><td>£0</td><td>£1,500</td><td>£500</td></tr><tr><td>Dec-18</td><td>£0</td><td>£500</td><td>-£500</td></tr><tr><td>Jan-19</td><td>£0</td><td>£1,500</td><td>£500</td></tr><tr><td>Feb-19</td><td>£0</td><td>£1,500</td><td>£500</td></tr><tr><td>Mar-19</td><td>£0</td><td>£2,000</td><td>£500</td></tr></tbody></table>	Month	Actual	Control total	Internal plan	Apr-18	-£2,500	-£2,500	-£1,500	May-18	-£1,500	-£500	£500	Jun-18	-£1,000	£0	£500	Jul-18	£0	£500	£500	Aug-18	£0	-£500	£500	Sep-18	£0	£500	£500	Oct-18	£0	£1,500	£500	Nov-18	£0	£1,500	£500	Dec-18	£0	£500	-£500	Jan-19	£0	£1,500	£500	Feb-19	£0	£1,500	£500	Mar-19	£0	£2,000	£500	The Trust reported a deficit position of £869k in June, significantly behind the in month plan and control total plan. This results in a year to date position of £3.2m deficit. This is significantly behind the Trust's internal plan deficit for Quarter 1 of £631k. Further analysis of this position can be found in the finance report.																				
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<div>NHS Improvement Single Oversight Framework - Use of Resource Metric</div> <div></div>	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.	<table><thead><tr><th>Element</th><th>Plan</th><th>Actual</th></tr></thead><tbody><tr><td>Capital Service Cover</td><td>4</td><td>4</td></tr><tr><td>Liquidity</td><td>1</td><td>1</td></tr><tr><td>I&E Margin</td><td>4</td><td>4</td></tr><tr><td>I&E Variance From Plan</td><td>1</td><td>1</td></tr><tr><td>Agency</td><td>2</td><td>3</td></tr><tr><td>Financial Sustainability Risk Rating</td><td>3</td><td>3</td></tr></tbody></table>	Element	Plan	Actual	Capital Service Cover	4	4	Liquidity	1	1	I&E Margin	4	4	I&E Variance From Plan	1	1	Agency	2	3	Financial Sustainability Risk Rating	3	3	The Trust reported a 3 in June, in line with the planned risk rating. The current rate of agency spend is adding further risk here.																																																			
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<div>Agency spend in relation to pay spend</div> <div></div>	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.	<table><thead><tr><th>Month</th><th>Actual</th><th>Ceiling</th></tr></thead><tbody><tr><td>Apr-17</td><td>£350</td><td>£480</td></tr><tr><td>May-17</td><td>£420</td><td>£480</td></tr><tr><td>Jun-17</td><td>£450</td><td>£480</td></tr><tr><td>Jul-17</td><td>£400</td><td>£480</td></tr><tr><td>Aug-17</td><td>£380</td><td>£480</td></tr><tr><td>Sep-17</td><td>£300</td><td>£480</td></tr><tr><td>Oct-17</td><td>£350</td><td>£480</td></tr><tr><td>Nov-17</td><td>£320</td><td>£480</td></tr><tr><td>Dec-17</td><td>£400</td><td>£480</td></tr><tr><td>Jan-18</td><td>£520</td><td>£480</td></tr><tr><td>Feb-18</td><td>£300</td><td>£480</td></tr><tr><td>Mar-18</td><td>£580</td><td>£480</td></tr><tr><td>Apr-18</td><td>£550</td><td>£480</td></tr><tr><td>May-18</td><td>£350</td><td>£480</td></tr><tr><td>Jun-18</td><td>£350</td><td>£480</td></tr><tr><td>Jul-18</td><td>£350</td><td>£480</td></tr><tr><td>Aug-18</td><td>£350</td><td>£480</td></tr><tr><td>Sep-18</td><td>£350</td><td>£480</td></tr><tr><td>Oct-18</td><td>£350</td><td>£480</td></tr><tr><td>Nov-18</td><td>£350</td><td>£480</td></tr><tr><td>Dec-18</td><td>£350</td><td>£480</td></tr><tr><td>Jan-19</td><td>£350</td><td>£480</td></tr><tr><td>Feb-19</td><td>£350</td><td>£480</td></tr></tbody></table>	Month	Actual	Ceiling	Apr-17	£350	£480	May-17	£420	£480	Jun-17	£450	£480	Jul-17	£400	£480	Aug-17	£380	£480	Sep-17	£300	£480	Oct-17	£350	£480	Nov-17	£320	£480	Dec-17	£400	£480	Jan-18	£520	£480	Feb-18	£300	£480	Mar-18	£580	£480	Apr-18	£550	£480	May-18	£350	£480	Jun-18	£350	£480	Jul-18	£350	£480	Aug-18	£350	£480	Sep-18	£350	£480	Oct-18	£350	£480	Nov-18	£350	£480	Dec-18	£350	£480	Jan-19	£350	£480	Feb-19	£350	£480	Agency expenditure reduced in June compared to month 1 and 2, with spend equating to 2.63% of the overall pay bill. Although this is an improvement in month, the year to date position remains high with 3.7% of pay expenditure relating to agency staffing.
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Finance and Efficiency - June 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Outpatient activity against plan 	The chart shows the position against plan for outpatient activity. The data includes all outpatient attendances - new and follow-up, consultant and non-consultant led.		<p>Outpatient activity was 6.7% below plan in June but is 2.1% above plan year to date. Further information is provided in the Chief Operating Officer's report to board.</p> <p>The phasing of this year's plan has now been reviewed and minor adjustments agreed with the Clinical Directorates.</p>
Elective activity against plan 	The chart shows the position against plan for elective activity. The data includes inpatient and day case elective admissions.		<p>Elective activity was 4.4% below plan in June but is 0.3% above plan year to date. Further information is provided in the Chief Operating Officer's report to board.</p> <p>The phasing of this year's plan has now been reviewed and minor adjustments agreed with the Clinical Directorates.</p>
Non-elective activity against plan 	The chart shows the position against plan for non-elective activity (emergency admissions).		<p>Non-elective activity was 2.6% below plan in June and is 3.7% below plan year to date.</p>
A&E activity against plan 	The chart shows the position against plan for A&E attendances at Harrogate Emergency Department. The data excludes planned follow-up attendances at A&E.		<p>A&E attendances remain significantly above plan - by 9.5% in June. Work is continuing to better understand the reasons for this increase, in discussion with HARD CCG.</p>

Finance and Efficiency - June 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Community Care Teams - patient contacts 	<p>The chart shows the number of face to face patient contacts for the community care teams.</p>	<p>Legend: No. contacts (blue line with diamond markers), HDFT average (green line).</p>	<p>There were 11,300 face to face patient contacts in June, a decrease on last month. 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.</p>

Operational Performance - June 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation																																																
<div>NHS Improvement Single Oversight Framework</div> <div>✓</div>	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 performance forms part of this assessment.	<table><thead><tr><th>Standard</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th>YTD</th></tr></thead><tbody><tr><td>RTT incomplete pathways</td><td>90.8%</td><td></td><td></td><td></td><td>90.8%</td></tr><tr><td>A&E 4-hour standard</td><td>94.8%</td><td></td><td></td><td></td><td>94.8%</td></tr><tr><td>Cancer - 62 days</td><td>87.3%</td><td></td><td></td><td></td><td>87.3%</td></tr><tr><td>Diagnostic waits</td><td>98.4%</td><td></td><td></td><td></td><td>98.4%</td></tr><tr><td>Dementia screening - Step 1</td><td>95.6%</td><td></td><td></td><td></td><td>95.6%</td></tr><tr><td>Dementia screening - Step 2</td><td>95.7%</td><td></td><td></td><td></td><td>95.7%</td></tr><tr><td>Dementia screening - Step 3</td><td>97.4%</td><td></td><td></td><td></td><td>97.4%</td></tr></tbody></table>	Standard	Q1	Q2	Q3	Q4	YTD	RTT incomplete pathways	90.8%				90.8%	A&E 4-hour standard	94.8%				94.8%	Cancer - 62 days	87.3%				87.3%	Diagnostic waits	98.4%				98.4%	Dementia screening - Step 1	95.6%				95.6%	Dementia screening - Step 2	95.7%				95.7%	Dementia screening - Step 3	97.4%				97.4%	<p>In Quarter 1, HDFT's performance was below the required level for 3 of the operational performance metrics - 18 weeks, the A&E 4-hour standard the 6-week diagnostic waiting times standard, as detailed below and in this month's Chief Operating Officer's report.</p> <p>Performance against the diagnostic waiting times standard deteriorated in June, following an improvement the previous month and it is disappointing that we did not achieve the 99% standard of patients waiting less than 6 weeks, as anticipated.</p>
Standard	Q1	Q2	Q3	Q4	YTD																																														
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Dementia screening - Step 2	95.7%				95.7%																																														
Dementia screening - Step 3	97.4%				97.4%																																														
<div>RTT Incomplete pathways performance</div> <div>✓</div>	<p>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.</p> <p>A high percentage is good.</p>		<p>Performance was at 91.0% in June, remaining below the minimum standard of 92%. The same two specialties (Trauma & Orthopaedics and Ophthalmology) remain below the 92% standard.</p>																																																
<div>A&E 4 hour standard</div> <div>✓</div>	<p>Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%.</p> <p>The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good.</p>		<p>HDFT's Trust level performance for June was 94.9%, below the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED was at 93.9% in June. The Trust is therefore below the required standard for Quarter 1 overall with a Trust level performance of 94.8%.</p>																																																
<div>Cancer - 14 days maximum wait from urgent GP referral for suspected cancer referrals</div> <div>✓</div>	<p>Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.</p>		<p>Provisional performance for June was at 96.7%, remaining above the 93% standard.</p>																																																

Operational Performance - June 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
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.		<p>Provisional performance for June was at 95.8%, an improvement on recent months and above the 93% standard. However because of the low performance during April and May, the Trust will fail this standard for Quarter 1, with performance at 87.4% for the quarter overall.</p> <p>The Clinical Directorates continue to work together to manage the volume of referrals received and match this with appropriate clinic capacity.</p>
Cancer - 31 days maximum wait from diagnosis to treatment for all cancers 	Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good.		Delivery at expected levels.
Cancer - 31 day wait for second or subsequent treatment: Surgery 	Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good.		Delivery at expected levels.
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug 	Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good.		Delivery at expected levels.






Operational Performance - June 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
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.		Provisional performance for June was above the required 85% standard at 87.3% with 8 accountable breaches. Of the 11 tumour sites, 4 had performance below 85% in June - head & neck (0.5 breach), lung (0.5), upper gastrointestinal (2.5) and urological (4.0). 2 patients waited over 104 days in June. The main reasons for the delays were patient choice and complex diagnostic pathways.
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.		Delivery at expected levels.
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.		Delivery at expected levels.
Children's Services - 10-14 day new birth visit 	<p>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.</p> <p>Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham, Middlesbrough and Stockton. A high percentage is good. The contract does not specify a required level.</p>		<p>In May, the validated performance position is that 94% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth.</p> <p>The data is reported a month in arrears so that the validated position can be shared. The chart presents a combined performance position for all Children's Services contracts and includes data for Stockton from April 2018 onwards.</p>

Operational Performance - June 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Children's Services - 2.5 year review 	<p>The percentage of children who had a 2.5 year review. A high percentage is good.</p> <p>Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham, Middlesbrough and Stockton. A high percentage is good. The contract does not specify a required level.</p>		<p>In May, the validated performance position is that 94% of children were recorded on Systmone as having had a 2.5 year review.</p> <p>The data is reported a month in arrears so that the validated position can be shared. The chart presents a combined performance position for all Children's Services contracts and includes data for Stockton from April 2018 onwards.</p>
OPEL level - Community Care Teams 	<p>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.</p>	<p>to be added</p>	<p>The Trust has been using the OPEL measure for community services since November 2017. This has been shared within the Trust on operational reports each day. From the beginning of June, the information is being recorded and retained in a database so that we can start to track the trend over time. During June, the OPEL level was reported at 2 for 28 out of 30 days during the month.</p>
Stranded patients 	<p>This indicator shows the average number of patients that were in the hospital with a length of stay of over 7 days (defined as stranded patients by NHS Improvement) or over 21 days (super-stranded patients). A low number is good.</p>		<p>The number of stranded and super-stranded patients at HDFT remained fairly static in June. However we are still identified as an outlier when compared to other local Trusts.</p> <p>NHS Improvement has set improvement trajectories for Trusts to reduce the number of super-stranded patients by around 25% by December 2018. HDFT's trajectory has been set at 53, which equates to a 27% improvement on the 2017/18 baseline position.</p>

Data Quality - Exception Report

Report section	Indicator	Data quality rating	Further information
Quality	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.
Quality	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.
Finance and efficiency	Theatre utilisation	Amber 	<p>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.</p> <p>The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc.</p> <p>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.</p>
Operational Performance	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.
Operational Performance	OPEL level - Community Care Teams	Amber 	This indicator is in development.

Indicator traffic light criteria

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Quality	Pressure ulcers - hospital acquired	No. category 3 and category 4 avoidable hospital acquired pressure ulcers	tbc	tbc
Quality	Pressure ulcers - community acquired	No. category 3 and category 4 community acquired pressure ulcers	tbc	tbc
Quality	Safety thermometer - harm free care	% harm free	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%.
Quality	Safety thermometer - harm free care - community care teams	% harm free		
Quality	Falls	IP falls per 1,000 bed days	Blue if YTD position is a reduction of >=50% of HDFT average for 2017/18, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2017/18, Amber if YTD position is a reduction of up to 20% of HDFT average for 2017/18, Red if YTD position is on or above HDFT average for 2017/18.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	Infection control	No. hospital acquired C.diff cases	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, NHS Improvement and contractual requirement
Quality	Avoidable admissions	The number of avoidable emergency admissions to HDFT as per the national definition.	tbc	tbc
Quality	Mortality - HSMR	Hospital Standardised Mortality Ratio (HSMR)	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
Quality	Mortality - SHMI	Summary Hospital Mortality Index (SHMI)		
Quality	Complaints	No. complaints, split by criteria	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.
Quality	Incidents - all	Incidents split by grade (hosp and community)	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
Quality	Incidents - comprehensive SIRIs and never events	The number of comprehensive SIRIs and the number of never events reported in the year to date. The indicator includes hospital and community data.	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
Quality	Friends & Family Test (FFT) - Patients	% recommend, % not recommend - combined score for all services currently doing patient FFT	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
Quality	Friends & Family Test (FFT) - Adult Community Services	% recommend, % not recommend - combined score for all services currently doing patient FFT		
Quality	Safer staffing levels	RN and CSW - day and night overall fill rates at trust level	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
Quality	Staff appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months	Annual rolling total - 90% green. Amber between 70% and 90%, red<70%.	Locally agreed target level based on historic local and NHS performance
Quality	Mandatory training rate	Latest position on the % staff trained for each mandatory training requirement	Blue if latest month >=95%; Green if latest month 75%-95% overall, amber if between 50% and 75%, red if below 50%.	Locally agreed target level - no national comparative information available until February 2016
Quality	Staff sickness rate	Staff sickness rate	Green if <3.9% , amber if between 3.9% and regional average, Red if > regional average.	HDFT Employment Policy requirement. Rates compared at a regional level also
Quality	Staff turnover	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
Finance and efficiency	Readmissions	No. emergency readmissions (following elective or non-elective admission) within 30 days.	Blue if latest month rate < LCL, Green if latest month rate < HDFT average for 2017/18, Amber if latest month rate > HDFT average for 2017/18 but below UCL, red if latest month rate > UCL.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Finance and efficiency	Length of stay - elective	Average LOS for elective patients	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Finance and efficiency	Length of stay - non-elective	Average LOS for non-elective patients		
Finance and efficiency	Theatre utilisation	% of theatre time utilised for elective operating sessions	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.
Finance and efficiency	Delayed transfers of care	% acute beds occupied by patients whose transfer is delayed - snapshot on last Thursday of the month.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Finance and efficiency	Outpatient DNA rate	% first OP appointments DNA'd	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Finance and efficiency	Outpatient new to follow up ratio	No. follow up appointments per new appointment.		
Finance and efficiency	Day case rate	% elective admissions that are day case		
Finance and efficiency	Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s)		
Finance and efficiency	NHS Improvement Financial Performance Assessment	An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.	Green if rating =4 or 3 and in line with our planned rating, amber if rating = 3, 2 or 1 and not in line with our planned rating.	as defined by NHS Improvement
Finance and efficiency	Capital spend	Cumulative capital expenditure	Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan	Locally agreed targets.
Finance and efficiency	Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis (£'s).	Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill.	Locally agreed targets.
Finance and efficiency	Outpatient activity against plan (new and follow up)	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.
Finance and efficiency	Elective activity against plan	Includes inpatient and day case activity		Locally agreed targets.
Finance and efficiency	Non-elective activity against plan			Locally agreed targets.
Finance and efficiency	Emergency Department attendances against plan	Excludes planned followup attendances.		Locally agreed targets.
Finance and efficiency	Community Care Teams - patient contacts	Face to face patient contacts	tbc	Locally agreed metric
Operational Performance	NHS Improvement governance rating	Trust performance on Monitor's risk assessment framework.	As per defined governance rating	as defined by NHS Improvement
Operational Performance	RTT Incomplete pathways performance	% incomplete pathways within 18 weeks	Green if latest month >=92%, Red if latest month <92%.	NHS England
Operational Performance	A&E 4 hour standard	% patients spending 4 hours or less in A&E.	Blue if latest month >=97%, Green if >=95% but <97%, 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%.
Operational Performance	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	% urgent GP referrals for suspected cancer seen within 14 days.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	% GP referrals for breast symptomatic patients seen within 14 days.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	% cancer patients starting first treatment within 31 days of diagnosis	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 31 day wait for second or subsequent treatment: Surgery	% cancer patients starting subsequent surgical treatment within 31 days	Green if latest month >=94%, Red if latest month <94%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	% cancer patients starting subsequent anti-cancer drug treatment within 31 days	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	% cancer patients starting first treatment within 62 days of urgent GP referral	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from consultant screening service referral	% cancer patients starting first treatment within 62 days of referral from a consultant screening service	Green if latest month >=90%, Red if latest month <90%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from consultant upgrade	% cancer patients starting first treatment within 62 days of consultant upgrade	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Children's Services - 10-14 day new birth visit	% new born visit within 14 days of birth	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
Operational Performance	Children's Services - 2.5 year review	% children who had a 2 and a half year review	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
Operational Performance	OPEL level - Community Care Teams	OPEL (Operational Pressures Escalation Level) experienced by the community care teams	tbc	Locally agreed metric
Operational Performance	Stranded patients	Average number of stranded patients (LOS >7 days) and super-stranded patients (LOS >21 days).	tbc	as defined by NHS Improvement

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

Date of Meeting:	25 July 2018	Agenda item:	7.0								
Report to:	Board of Directors										
Title:	Finance Report										
Sponsoring Director:	Jonathan Coulter Deputy Chief Executive / Finance Director										
Author(s):	Finance Department										
Report Purpose:	<table border="1" style="width: 100%;"> <tr> <td>Decision</td><td></td> <td>Discussion/ Consultation</td><td>✓</td> <td>Assurance</td><td>✓</td> <td>Information</td><td>✓</td> </tr> </table>			Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<ul style="list-style-type: none"> The Trust reported a deficit position of £869k in month. This equates to an in month adverse variance of £1,355k against the Trusts internal plan. This results in a year to date deficit of £3.2m, significantly behind the year to date internal plan of a £0.6m deficit. This position includes full receipt of quarter one Provider Sustainability Funding. Key drivers for this variance relate to Ward Pay expenditure, Theatres Pay expenditure and CIP achievement. 										
Related Trust Objectives											
<table border="1" style="width: 100%;"> <tr> <td>To deliver high quality care</td><td>✓</td> <td>To work with partners to deliver integrated care:</td><td>✓</td> <td>To ensure clinical and financial sustainability:</td><td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓						
Key implications											
Risk Assessment:	The paper outlines the financial risks facing the Trust and the mitigations being put in place to resolve these in terms of revenue and cash.										
Legal / regulatory:	None directly identified.										
Resource:	The document outlines the financial challenges and approach to resolving these issues.										
Impact Assessment:	A number of quality impact assessments are undertaken on elements of the recovery plan and CIP programme.										
Conflicts of Interest:	None										
Reference documents:											

Action Required by the Board of Directors:

The Board of Directors is asked to note the contents of this report and the actions that are being progressed to achieve the financial plan.

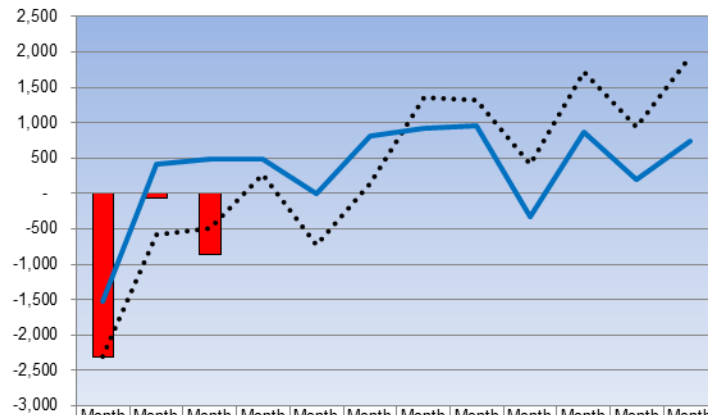
The Board is also asked to confirm and approve the relevant points in relation to the Reference Costs submission included in the finance report.

June 2018 Financial Position

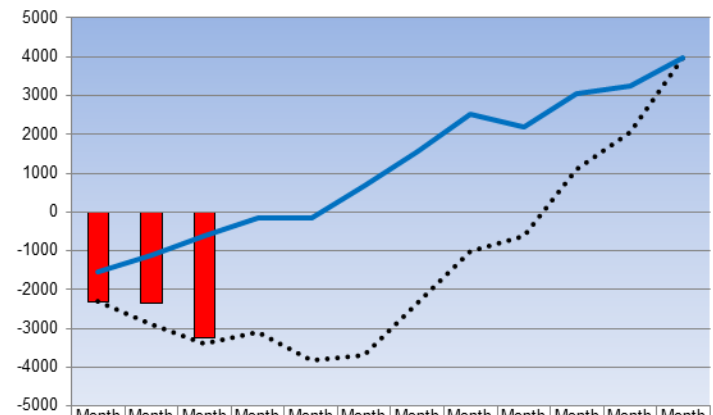
Financial Performance

- As highlighted below, the Trust reported a deficit position of £869k in month. This equates to an in month adverse variance of £1,355k against the Trusts internal plan. This results in a year to date deficit of £3.2m, significantly behind the year to date internal plan of a £0.6m deficit.

HDFT Monthly Financial Performance (£'000s)



HDFT Cumulative Financial Performance (£'000s)



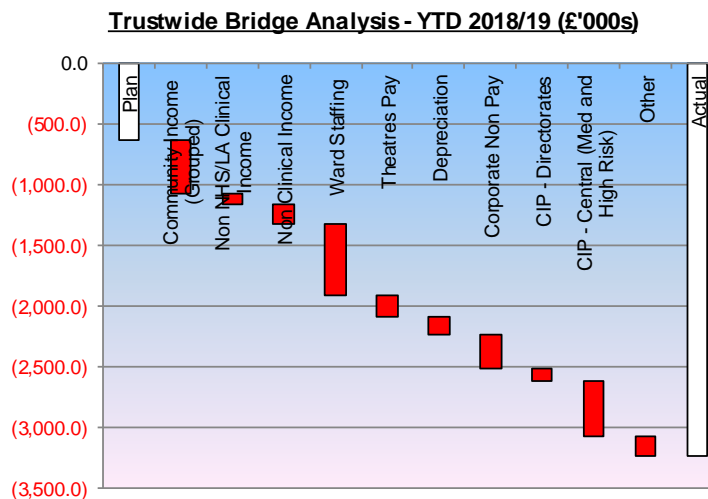
- This continued deficit run rate is a significant concern. Although a deficit in Quarter 1 was anticipated, the level reported means that further improvements will be needed to the run rate than originally planned to make up this loss.
- However, as a result of being ahead of the external plan set with NHS Improvement, the Trust is currently reporting full achievement of the Provider Sustainability Funding (PSF, formally Sustainability and Transformation Funding).
- Both criteria are assumed as achieved, with discussions ongoing regarding the allocation for A&E performance. The Trust will therefore receive Q1 PSF for financial performance in the usual timescales, however, there is likely to be a delay in receiving the performance element.
- All Sustainability and Transformation Funding for 2017/18 has now been received.

June 2018 Financial Position

Financial Performance Cont.

- The drivers for this position are highlighted in the following information -

Variance to Budget	£'000s
Plan	(631)
Community Income (Grouped)	(445)
Non NHS/LA Clinical Income	(95)
Non Clinical Income	(161)
Ward Staffing	(587)
Theatres Pay	(172)
Depreciation	(143)
Corporate Non Pay	(279)
CIP - Directorates	(105)
CIP - Central (Med and High Risk)	(453)
Other	(160)
Actual	(3,231)



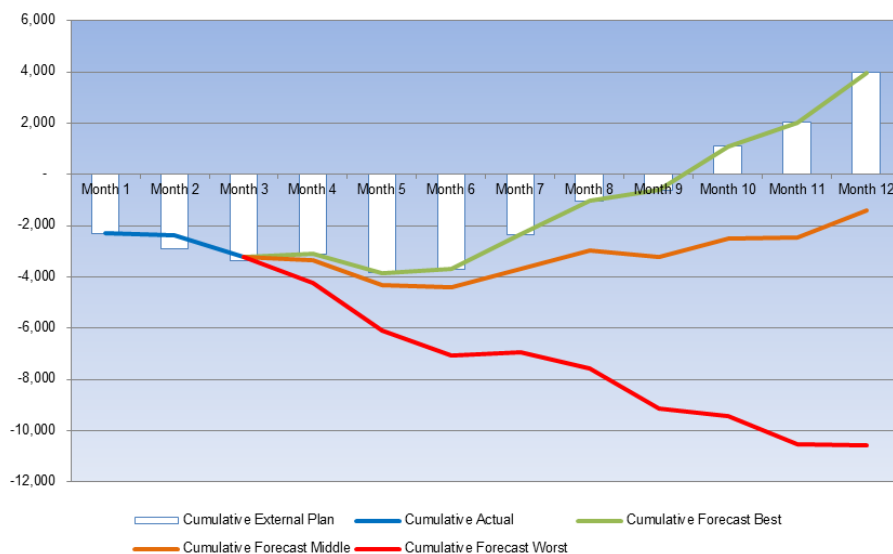
- The headline messages for Trustwide financial performance are therefore –
 - Ward staffing continues to be a significant area of overspend, with underlying expenditure needing to be addressed.***
 - CIP delivery is not at 100% as at the end of June. A number of plans have been actioned, however, at the same time a number of schemes have been rationalised and the anticipated benefit is lower. Work is ongoing to close this gap.***
 - Although specific areas of capacity remain challenged, acute clinical income is generally at planned levels. There are a number of areas under recovering income outside of this which are being addressed. It should also be noted that while Acute Income is at plan, profiling means an increase in income, and therefore activity, is expected in the second part of the year.***
 - Some areas of non pay remain a pressure and actions are being developed locally to manage this (Corporate for example).***

June 2018 Financial Position

Financial Performance Cont.

- The following forecast outturn scenarios outline the financial impact of the risks currently faced by the Trust. This has been discussed in detail with NHSI.

Forecast Outturn Scenarios as at end of Q1 2018 (£'000s)



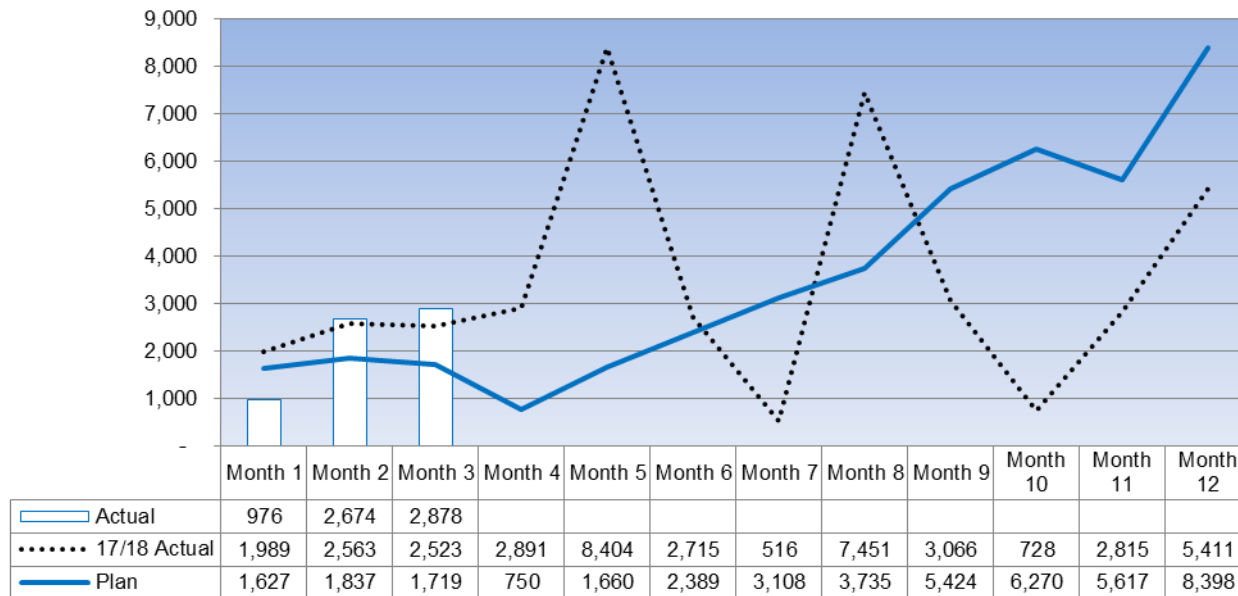
	Best Case £m	Medium Case £m	Worse case £m
Plan	4	4	4
Ward staffing pressures	-0.5	-1.2	-2.4
theatre staffing	-0.3	-0.5	-1
CIP delivery		-1.4	-3
Income risk			-0.5
historic issues	-1	-1	-3.8
depreciation	-0.4	-0.4	-0.4
living wage	0.3	0.2	0.1
CIP contingency	1.9	1.9	1.9
S&T funding impact		-2	-3.5
sub-total	4	-0.4	-8.6
w inter costs		-0.7	-1.5
pay award funding - calculation		-0.3	-0.3
pay award funding - HHFM			-0.2
TOTAL	4	-1.4	-10.6

June 2018 Financial Position

Cash and Capital resource

- Cash remains a significant risk for the Trust, with a need to establish some recovery and resilience while providing resource for a limited capital programme. The cash position at the end of June was £2,878k. Although this is ahead of plan, any favourable variance needs to be seen in the context of the overall improvement required during 2018/19. The position therefore remains significantly pressured.

Monthly Cash Position 2018/19 (£'000s)



- It should be noted this position includes the cash position of HHFM, as well as a number of payments that were received at the end of June to support the Trusts position.
- It is currently taking the Trust over 60 days to pay 95% of invoices (no. and value), twice the time recommended. The Trusts current performance for the Better Payment Practice Code equates to 7.4% of invoices, 40.2% of invoice value. Levels of cash mean this remains challenging, and in order to support the Trust in improving this position NHS Improvement have been approached around sharing of best practice for cash management.

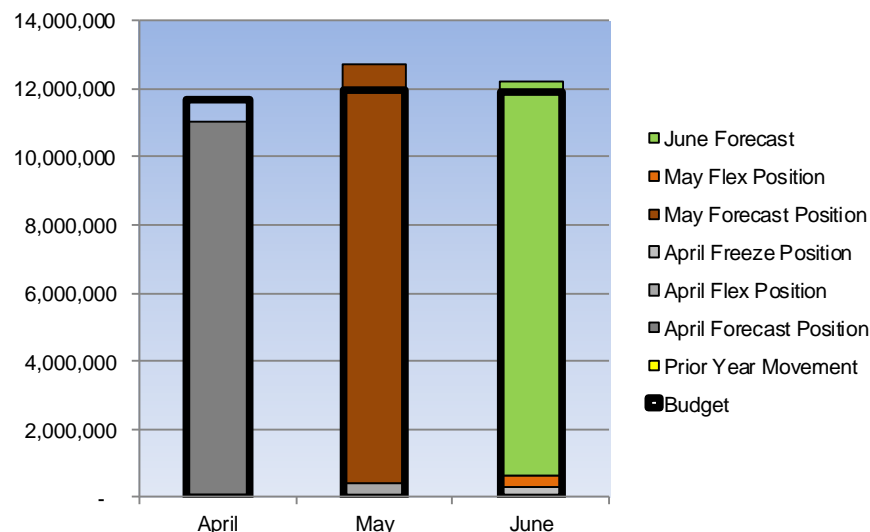
June 2018 Financial Position

Income and Activity

- Overall, the Trust reported a year to date favourable variance of £361k for NHS clinical income. This is a positive reflection on the planning which was undertaken for 2018/19. There are some challenges in this position which are being addressed at directorate level.

Income Reporting (£'s)	April	May	June	YTD
Budget	11,652,913	11,973,467	11,923,534	35,549,914
Prior Year Movement	78,799	- 18,267	25,782	86,314
April Forecast Position	10,933,806			10,933,806
April Flex Position		443,440	-	443,440
April Freeze Position			284,639	284,639
May Forecast Position		12,270,542		12,270,542
May Flex Position			358,977	358,977
June Forecast			11,533,196	11,533,196
Total Actual	11,012,605	12,695,715	12,202,594	35,910,914
Variance	- 640,308	722,248	279,060	361,000

Percentage Variance	-5.49%	6.03%	2.34%	1.02%
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- The current income position for the top 5 commissioners based on annual contract values is highlighted in the table below. This equates to 88% of the Trust's planned income.

Commissioner	YTD Plan	YTD Actual	Variance	% Variance
HaRD CCG	25,903,449	26,713,066	809,617	3%
Leeds CCGs	6,772,100	6,753,555	- 18,545	0%
NHS England	4,411,411	5,296,305	884,894	20%
Durham Council	2,875,471	2,880,398	4,927	0%
North Yorkshire County Council	1,964,499	1,930,639	- 33,860	-2%

June 2018 Financial Position

Activity extract from Chief Operating Officer Report

1.0 SERVICE ACTIVITY

The table below summarises the June 2018 position on activity for the main points of delivery, along with the June 2017 year-to-date position for comparison.

	Jun-17 YTD			May-18			Jun-18			Jun-18 YTD		
Activity type	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
New outpatients	23748	23722	0.1%	8614	7945	8.4%	8204	8296	-1.1%	24489	24020	2.0%
Follow-up outpatients	47073	47578	-1.1%	16224	15697	3.4%	14799	16390	-9.7%	46473	47717	-2.6%
Elective inpatients	899	962	-6.5%	302	313	-3.5%	285	312	-8.8%	884	916	-3.5%
Elective day cases	6941	7543	-8.0%	2625	2441	7.6%	2481	2583	-3.9%	7546	7625	-1.0%
Non-electives	5529	5314	4.0%	1909	1905	0.2%	1756	1807	-2.8%	5330	5520	-3.4%
A&E attendances	13217	12093	9.3%	4769	4279	11.5%	4534	4141	9.5%	13617	12560	8.4%

Consultant-led new outpatient appointments and Consultant-led outpatient procedures were very close to plan in June, and Consultant-led follow-up appointments were 5% below plan for the month. This balance reflects the ongoing demand for new patient appointments, and the focus over June was on ensuring new patient clinics were in place. This was achieved against a backdrop of ongoing challenges with middle grade gaps, in particular in General Surgery, Orthopaedics and Obs & Gynae.

Elective inpatients were 8.8% behind plan for the month, with Gynaecology and Trauma & Orthopaedics (T&O) behind plan. For T&O this is related to a reduction in uptake for Saturday lists which was linked to Consultant leave, and in Gynaecology this is linked to a reduction in capacity due to an ongoing HR issue. Work is ongoing to maximise inpatient work, in particular to cover the gap left by the Locum T&O Consultant finishing earlier than anticipated.

Day cases remain marginally below plan and there has been an increase in Endoscopy day case work from the last week in June with the new unit opening and the utilisation of temporary staff to cover the recruitment gap. This has allowed further lists to be added on a daily basis.

Workforce Efficiency Group

Workforce Plan Performance

£'s	CHILDRENS AND COUNTY WIDE			CORPORATE SERVICES			LONG TERM AND UNSCHEDULED			PLANNED AND SURGICAL CARE			Trustwide		
	YTD budget	YTD Actual	YTD Variance	YTD budget	YTD Actual	YTD Variance	YTD budget	YTD Actual	YTD Variance	YTD budget	YTD Actual	YTD Variance	YTD budget	YTD Actual	YTD Variance
PERMANENT	9,978,570	9,330,443	648,127	3,174,320	3,021,339	152,981	13,138,667	12,277,420	861,247	11,593,415	10,855,793	737,622	39,624,339	37,107,704	2,516,635
BANK	13,973	52,604	-38,631	400	8,859	-8,459	44,549	295,514	-250,965	26,599	133,930	-107,331	86,295	537,237	-450,942
LOCUM	0	66,750	-66,750				78,100	701,442	-623,342	33,123	394,373	-361,250	111,223	1,211,907	-1,100,684
AGENCY	6,000	97,189	-91,189	3,948	52,667	-48,719	89,495	471,460	-381,965	80,898	675,573	-594,675	311,738	1,493,975	-1,182,237
Grand Total	9,998,543	9,546,986	451,557	3,178,668	3,082,865	95,803	13,350,811	13,745,836	-395,025	11,734,035	12,059,669	-325,634	40,133,595	40,350,823	-217,228

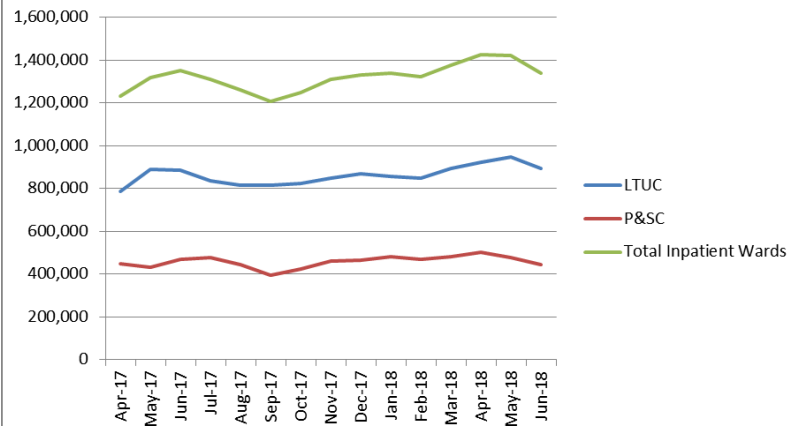
	June Budget WTE	June Contracted WTE	June Variance WTE	June Variance %
Adult Community Services	124.78	123.68	-1.10	-0.88%
Children's Services	620.21	588.68	-31.53	-5.08%
Medical Staffing	331.49	315.36	-16.13	-4.87%
Theatres and Day Surgery	134.78	107.49	-27.29	-20.25%
RN - Wards	384.27	356.71	-27.56	-7.17%
HCA - Wards	220.45	222.18	1.73	0.78%
Other	1,905.36	1,765.22	-140.14	-7.36%
Total	3,721.34	3,479.32	-242.02	-6.50%

	June Budget £'s	June Actual £'s	June Variance £'s	June Variance %	YTD Budget £'s	YTD Actual £'s	YTD Variance £'s	YTD Variance %
Adult Community Services	353,511	366,201	12,690	4%	1,060,317	1,133,008	72,691	7%
Children's Services	2,045,962	1,918,595	-127,367	-6%	6,144,281	5,772,454	-371,827	-6%
Medical Staffing	3,076,797	3,041,265	-35,532	-1%	9,393,541	9,330,037	-63,504	-1%
Theatres and Day Surgery	380,326	446,324	65,998	17%	1,151,886	1,344,181	192,295	17%
RN - Wards	1,324,054	1,394,179	70,125	5%	4,034,860	4,274,298	239,438	6%
HCA - Wards	464,961	551,036	86,075	19%	1,443,019	1,785,827	342,808	24%
Other	5,755,053	5,660,601	-94,452	-2%	17,235,341	17,017,037	-218,304	-1%
Total	13,400,664	13,378,202	-22,462	0%	40,463,245	40,656,843	193,598	0%

Note – the medical staffing position has been supported with £623k agency premium provision

Inpatient Ward Pay Spend – June 18

INPATIENT WARD PAY TREND



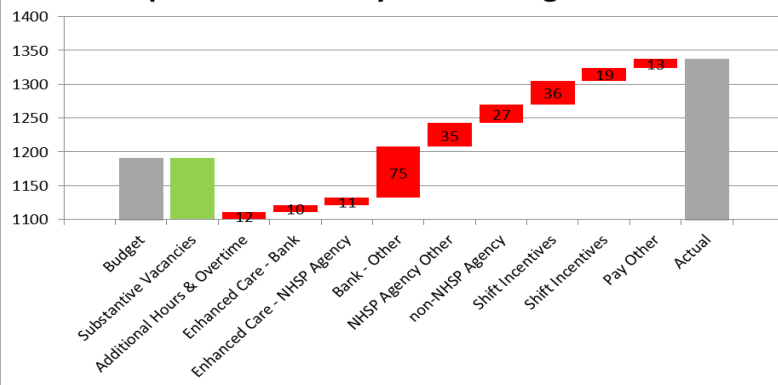
The inpatient ward spend in June 2018 is £1.337m which is £85k less than May's spend (£1.422m).

Pay shows an overspend of £147k versus budget with a cumulative overspend of £586k now year-to-date.

The overspend year-to-date run rate is equivalent to the cost of 57 WTE B5 nurses.

**note - Winter Pressure funding has been removed from the data and March entries accounted for in April have been moved to March in the above.*

Inpatient Wards Pay Versus Budget - June 18



Inpatient wards pay is overspent £147k in month

- Although we are seeing £91k savings on substantive posts, bank, agency, additional hours, overtime and incentive shifts were overspent by £238k.
- Bank and agency charges equate to £158k including NSHP invoices for enhanced care of £21k (reduced from spend of £30k in May and £66k in April).
- Above-cap usage charges have significantly declined at £27k and were nil for the third week in June. Within the £27k, are £16k in prior period charges.
- Looking at the bank and agency spend by shift date for June, it shows since mid-June the overall spend has come down from £42k to £25k per week.

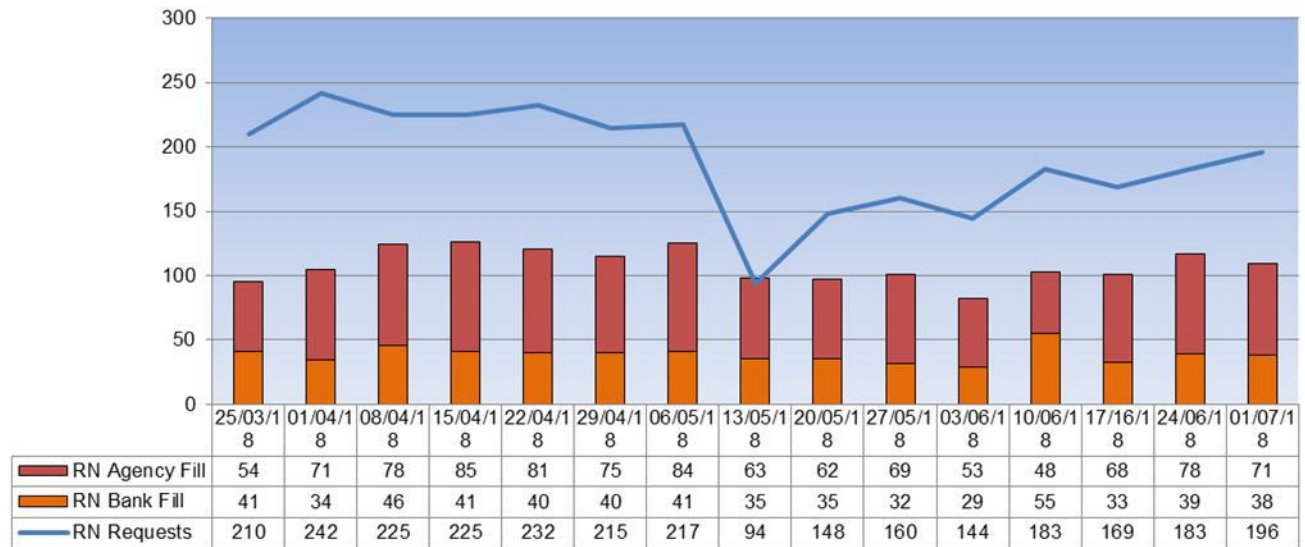
- Despite improvements, the overspend remains significant with vacancies being the main reason given for bank and agency shifts. We are currently undergoing a review of staffing levels to understand the true vacancy position taking into sickness, leavers, starters and supernumerary posts.
- We are reviewing all supernumerary time to confirm the costs of any unfunded supernumerary time and look to put remedial plans in place to either remove the unfunded costs or request funding for them going forward if essential.
- Shift incentive premiums remain in line with prior months but are to be stopped from September and those booked for August have been offered to NHSP as a cheaper alternative. Incentive shifts are c. 25-30% more expensive than bank and below-cap agency charges.

June 2018 Financial Position

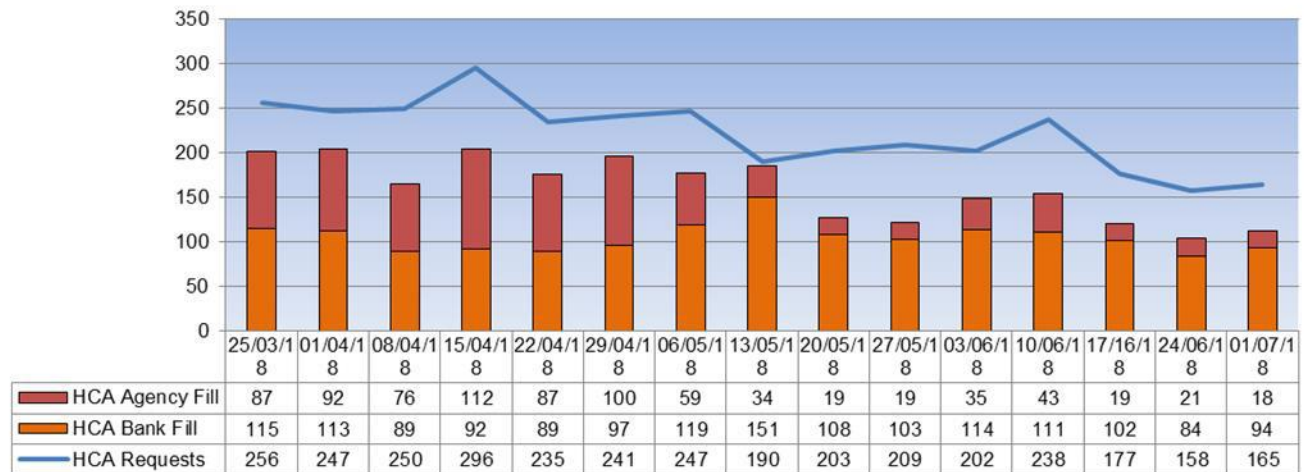
Workforce continued – Ward Nursing and Healthcare Assistants

- A number of actions have been put in place and will continue to be monitored through the Workforce Efficiency Group.
- As reported last month, there was an initial impact on the requests and fill of shifts, however, this did not have a material impact on the financial position. As well as this, there has been a small rise in recent weeks.
- Further focus has been placed on this in recent weeks and the impact will continue to be closely monitored.

Registered Nursing Bank requests, Bank and Agency Fill (Shifts)



HCA Bank requests, Bank and Agency Fill (Shifts)



June 2018 Financial Position

Workforce Continued – Medical Staffing

- The Workforce Efficiency Group also discussed the expenditure in relation to medical staffing. The spend is currently in line with the contingency in place at the start of the year, however, the level of expenditure means this continues to be a risk.

Agency cap breaches are outlined in the graph on the right. All agency shifts continue to be cap breaches.



Corporate – Non Pay

- As outlined on page 2, there is a significant adverse variance for Corporate Non Pay at present. This relates to –
 - Costs in relation to IT contracts
 - Costs in relation to property charge
- Both these areas require further investigation, with any actions taken forward through the Corporate Board Meeting.

June 2018 Financial Position

Cost Improvement Programme

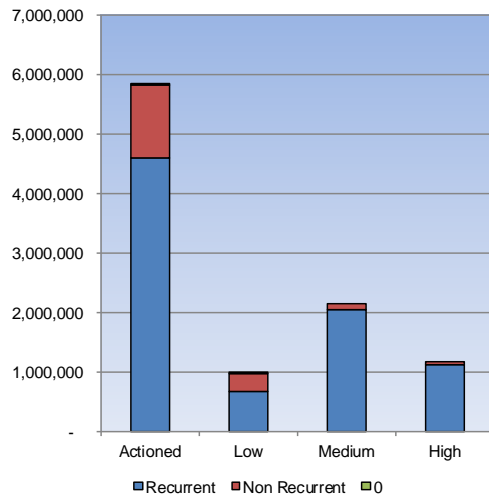
- The Trustwide CIP programme continues its development and implementation, with 95% of plans in place against the £10.7m target. This reduces to 82% following risk adjustment. Information by directorate is highlighted below, as well as progress against key schemes and areas with a high risk to delivery.

Trustwide Efficiency Programme Summary

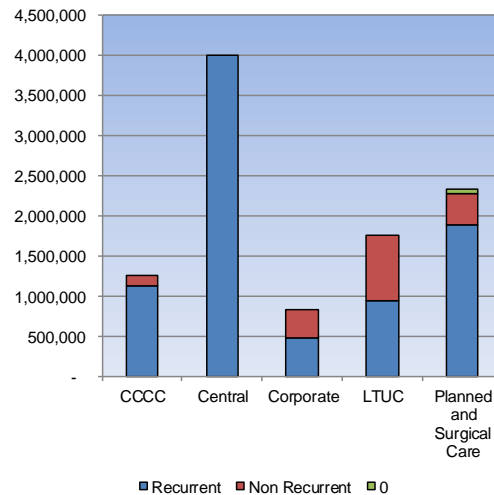
Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Trustwide Summary	10,700	5,845	998	2,154	1,170	10,167	95%	8,751	82%
% age of target			9%	20%	11%				

Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Children's and Countywide	1,133	665	524	64	0	1,252	111%	1,213	107%
Corporate	1,150	574	47	20	190	831	72%	672	58%
Other and/or Central Scheme	5,067	2,100	0	1,296	594	3,990	79%	3,256	64%
Long Term and Unscheduled	1,645	1,265	240	255	0	1,759	107%	1,696	103%
Planned and Surgical Care	1,705	1,242	188	519	386	2,336	137%	1,914	112%

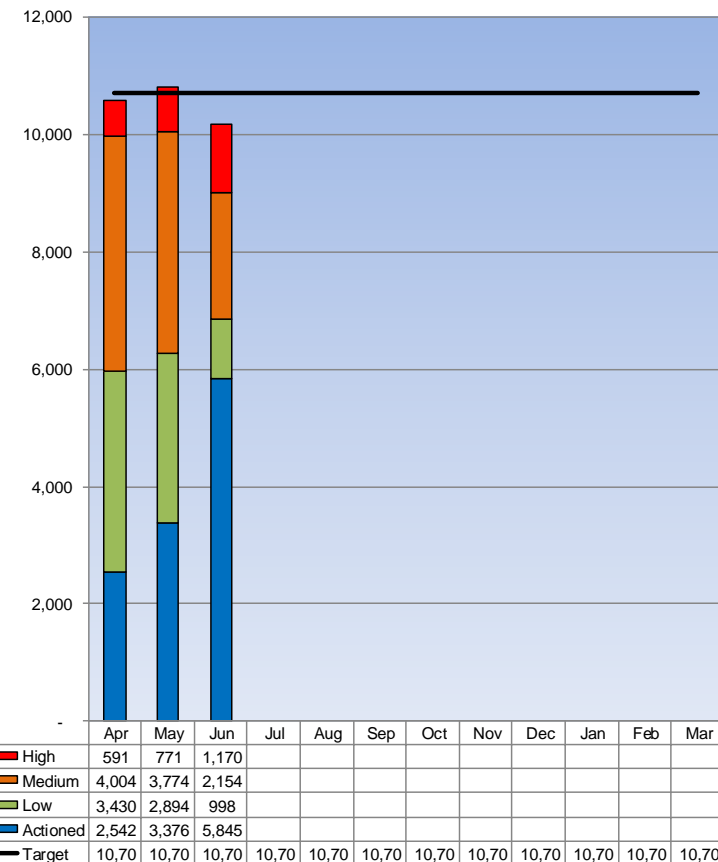
Recurrent/Non Recurrent Split by Risk Rating (£s)



Recurrent/Non Recurrent Split by Directorate (£s)



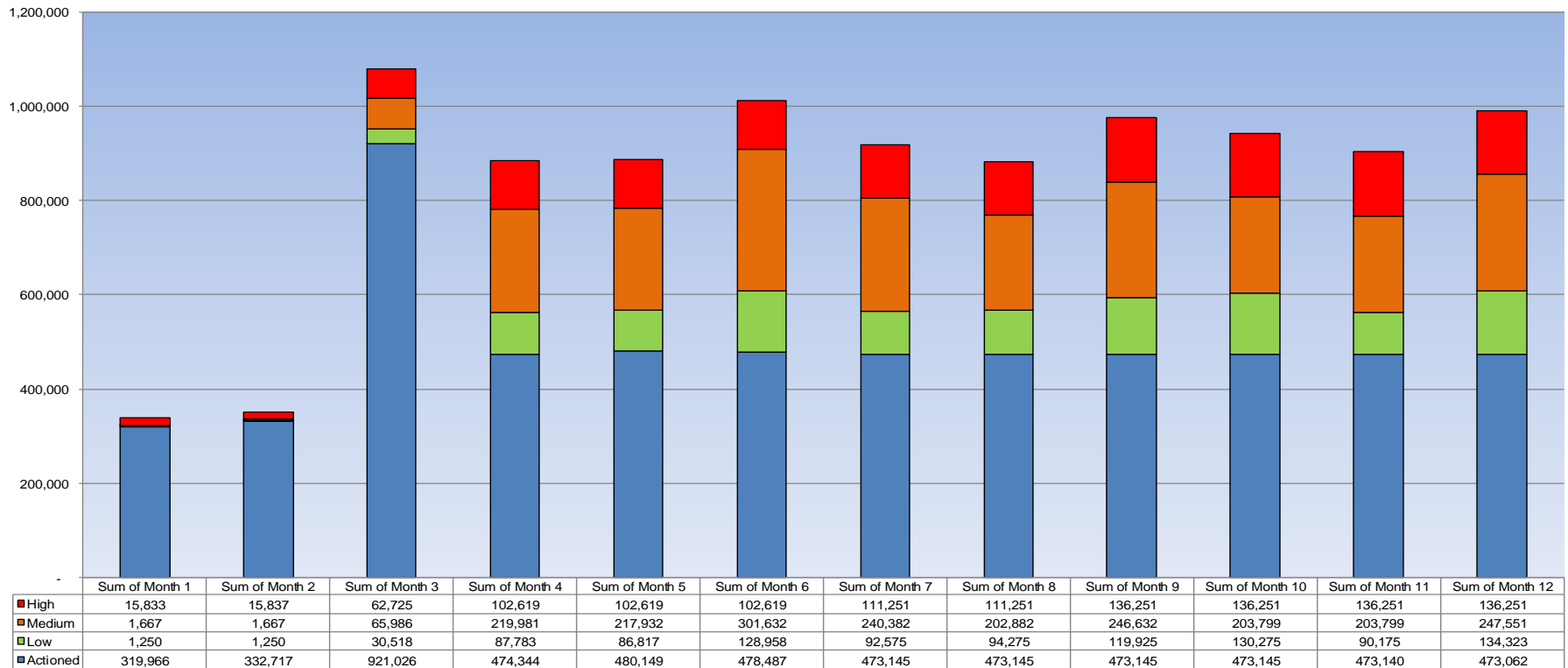
Monthly Progress Against Full Year Target (£'000s)



June 2018 Financial Position

Cost Improvement Programme Cont.

Efficiency Programme - Phasing of Plans (£'s)



Reference Cost Submission

The Board will be aware that the Trust has submitted Reference Cost information for many years. For the Reference Costs relating to 2017/18, the Board is required to confirm that the following in relation to the reference cost return (or provide details of non-compliance):

- the board or its appropriate sub-committee has approved the costing process ahead of the collection
- the finance director has, on behalf of the board, approved the final national costs collection return before the final submission
- the return has been prepared in accordance with the Approved Costing Guidance, which includes the national costs collection guidance
- information, data and systems underpinning the national costs collection return are reliable and accurate
- there are proper internal controls over the collection and reporting of the information included in the national costs collection, and these controls are subject to review to confirm that they are working effectively in practice
- costing teams are appropriately resourced to complete the national costs collection return, including the self-assessment quality checklist and validations, accurately within the timescales set out in the guidance.

Compliance with this requirement will form part of the costing assurance programme and may be subject to review by NHS Improvement.

The internal audit report in relation to this process is attached for information. The report offers *SIGNIFICANT ASSURANCE* in relation to the above.

Date of Meeting:	25 July 2018	Agenda item:	8.0								
Report to:	Board of Directors										
Title:	Chief Operating Officer's Report										
Sponsoring Director:	Mr Robert Harrison, Chief Operating Officer										
Author(s):	Ms Rachel McDonald, Head of Performance and Analysis Mr Jonathan Green, Information Analyst Specialist										
Report Purpose:	<table border="1"> <tr> <td>Decision</td> <td>✓</td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<ul style="list-style-type: none"> All cancer waiting times standards were achieved for Quarter 1, with the exception of the 2 week wait cancer waiting times standard for breast symptomatic patients which showed improvement in June but remained below the 93% standard for Quarter 1 overall. HDFT's performance against A&E 4-hour standard was below 95% in June and for Quarter 1 overall. 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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:	None										
Resource:	None identified.										
Impact Assessment:	Not applicable.										
Conflicts of Interest:											
Reference documents:											
Assurance:											
Action Required by the Board of Directors:											
<p>It is recommended that the Board/Committee:</p> <ul style="list-style-type: none"> <i>Note items included in the report.</i> 											

CHIEF OPERATING OFFICER'S REPORT

Board of Directors' meeting 25th July 2018

1.0 SERVICE ACTIVITY

The table below summarises the June 2018 position on activity for the main points of delivery, along with the June 2017 year-to-date position for comparison.

	Jun-17 YTD			May-18			Jun-18			Jun-18 YTD		
Activity type	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
New outpatients	23748	23722	0.1%	8614	7945	8.4%	8204	8296	-1.1%	24489	24020	2.0%
Follow-up outpatients	47073	47578	-1.1%	16224	15697	3.4%	14799	16390	-9.7%	46473	47717	-2.6%
Elective inpatients	899	962	-6.5%	302	313	-3.5%	285	312	-8.8%	884	916	-3.5%
Elective day cases	6941	7543	-8.0%	2625	2441	7.6%	2481	2583	-3.9%	7546	7625	-1.0%
Non-electives	5529	5314	4.0%	1909	1905	0.2%	1756	1807	-2.8%	5330	5520	-3.4%
A&E attendances	13217	12093	9.3%	4769	4279	11.5%	4534	4141	9.5%	13617	12560	8.4%

Consultant-led new outpatient appointments and Consultant-led outpatient procedures were very close to plan in June, and Consultant-led follow-up appointments were 5% below plan for the month. This balance reflects the ongoing demand for new patient appointments, and the focus over June was on ensuring new patient clinics were in place. This was achieved against a backdrop of ongoing challenges with middle grade gaps, in particular in General Surgery, Orthopaedics and Obs & Gynae.

Elective inpatients were 8.8% behind plan for the month, with Gynaecology and Trauma & Orthopaedics (T&O) behind plan. For T&O this is related to a reduction in uptake for Saturday lists which was linked to Consultant leave, and in Gynaecology this is linked to a reduction in capacity due to an ongoing HR issue. Work is ongoing to maximise inpatient work, in particular to cover the gap left by the Locum T&O Consultant finishing earlier than anticipated.

Day cases remain marginally below plan and there has been an increase in Endoscopy day case work from the last week in June with the new unit opening and the utilisation of temporary staff to cover the recruitment gap. This has allowed further lists to be added on a daily basis.

2.0 PAEDIATRIC MEDICAL STAFFING

Medical staffing in both acute and community paediatrics remains the most pressing issue for the CCCC directorate. Four candidates have been recruited for the CESR programme who will start from October 2018 onwards. However, the withdrawal of the two candidates from the Consultant Community Paediatrician post means that pressures on clinics and waiting times continue.

3.0 GATESHEAD AND SUNDERLAND CHILD HEALTH SERVICES

The organisation welcomed staff from Gateshead and Sunderland for the start of the new Child Health Services from the 1st July, the mobilisation of two large services at the same time requires significant support from the management team within the Directorate and corporate support teams, particularly due to the transition for all staff from a paper based service to one utilising technology and agile working methods.

4.0 COMMUNITY DENTAL SERVICE

Following the withdrawal of the second round of the tender process by the commissioners, the Community Dental Service wished to continue the progress made regarding the effectiveness and efficiency of the service. On that basis, the service managers have

started the consultation with staff about the proposed staffing structures to better deliver on specialist dental community requirements. This consultation will be over a 30 day period and managers are working closely with HR partners and staff side representatives.

5.0 NEUROPHYSIOLOGY CONSULTANT RECRUITMENT

York has given notice that they will no longer continue with the Neurophysiology alliance due to medical staffing gaps. Other local Trusts are being approached to see if they are able to offer us on site capacity but this leaves the Trust at risk of not having enough capacity to deal with requests for Neurophysiology investigations.

6.0 EMERGENCY DEPARTMENT PERFORMANCE

HDFT's Trust level performance against the 4-hour standard was 94.9% in June, below the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. The Trust is therefore below the required standard for Quarter 1 overall with a Trust level performance of 94.8%.

On 27th June 2018 Pauline Philip, National Director for Urgent and Emergency Care wrote to all providers stating that access to the performance based fund, Q1 performance payment will be made if on the A&E 4 hour target a trust achieves the higher of either 90% or an improvement on its own Q1 2017/18 performance. The letter went on to clarify the rules further and included the following important points:

- There will be no clawback of payments missed from previous quarters
- Required performance will be capped at the standard of 95% and so no trust will be expected to do better than the standard even if their 17/18 performance exceeded the standard
- Performance will be assessed across the whole quarter and monthly performance will not be used as part of the calculation

Therefore based on this letter HDFT would not be eligible for the Q1 Performance element of the PSF as the Trust exceeded 95% in the same quarter last year and therefore is expected to deliver 95% for Q1 and Q2. In addition, the Trust would not be eligible for part payment through the achievement of 95% in May 2018.

The Chief Operating Officer has therefore written to the local NHSI performance lead setting out the fact that the Trust saw, treated and discharged more patients within 4 hours in Q1 this year compared to last year, however growth in demand was significantly above the national planning guidance which meant the number of patients exceeding 4 hours was also significantly up. A response to this request to the PSF payment being supported is awaited.

7.0 DIAGNOSTIC WAITING TIMES PERFORMANCE

Performance against the diagnostic waiting times standard deteriorated in June, following an improvement the previous month and it is disappointing that we did not achieve the 99% standard of patients waiting less than 6 weeks, as anticipated.

This was mainly due to a significant number of breaches reported in Cardiology for patients awaiting Echo's. The work which is being undertaken to improve the number of rooms available in the Heart Centre has taken longer than anticipated and has resulted in the temporary loss of two rooms meaning the department have had to operate with reduced capacity for longer than expected. There were also issues due to administrative staff sickness within the department.

The work on the unit is due to be completed on the 6th August which will increase the capacity of the unit. To ensure the booking processes for these diagnostics are more robust, a skill mix review will be undertaken in the department to appoint more Band 2 staff

who are able to appoint patients. This will ensure the department has better cover arrangements and a more robust booking system. Locum cover has also been secured which will mitigate some of the demand within the department.

8.0 CANCER SERVICES

Performance

Performance against the 14 day standard for breast symptomatic patients was above the required 93% in June, but the standard was not delivered for Q1, with 87.4% of patients seen within 14 days. A review of capacity and demand for these services is ongoing across the WYAAT Trusts.

Provisional data indicates that Trust performance for the 62 day standard was above the 85% standard in June and Q1 with 87.3% of patients treated within 62 days for month and 87.2% for the quarter.

Inter-Provider Transfer (IPT) performance

As stated above, expected 62-day performance for June with the current allocation rules is at 87.3%. A total of 30 patients were treated at tertiary centres in Q1 following a 2WW referral to Harrogate. Of these, 19 were transferred by day 38 (63.3%). The transfer of patients by day 38 continues to be challenging with a small deterioration in performance when compared to last year. The Lung, Head and Neck and Prostate pathways account for the majority of post day 38 transfers, these areas often include complex diagnostic pathways (which require some diagnostics to be carried out by Leeds or York). The Cancer Steering Group is focused on improving the diagnostic pathways and the ability for HDFT to consistently transfer the majority of patients to tertiary providers prior to day 38. This links to the wider work on Early Diagnosis detailed below.

Shadow reporting of the 62 day standard shows that when the national re-allocation rules are applied, performance would have been 3.4% lower for June. The table below illustrate HDFT's actual reported performance and performance when re-allocation rules are applied.

ACTUAL performance	Apr-18	May-18	Jun-18	Q1
Total	46.0	51.0	63.0	160.0
Within 62 days	38.5	46.0	55.0	139.5
Outside 62 days	7.5	5.0	8.0	20.5
Performance	83.7%	90.2%	87.3%	87.2%
Re-allocation (NATIONAL)	Apr-18	May-18	Jun-18	Q1
Total	45.0	51.0	62.0	158.0
Within 62 days	37.0	46.5	52.0	135.5
Outside 62 days	8.0	4.5	10.0	22.5
Performance	82.2%	91.2%	83.9%	85.8%
Difference (National/Actual)	Apr-18	May-18	Jun-18	Q1
Total	-1.0	0.0	-1.0	-2.0
Within 62 days	-1.5	0.5	-3.0	-4.0
Outside 62 days	0.5	-0.5	2.0	2.0
% difference	-1.5%	1.0%	-3.4%	-1.4%
IPTs (actual patients) SENT	Apr-18	May-18	Jun-18	Q1
Total	8	10	12	30
Within 38 days	5	8	6	19
Outside 38 days	3	2	6	11
Performance	62.5%	80.0%	50.0%	63.3%

Early Diagnosis Project

The Trust has been successful in securing funding for the "Early Diagnosis of Cancer" project. The primary objective of the project is to plan sustainable improvements and systemic changes across fast-track referral patient pathways and diagnostics in HDFT with the aim of improving access to diagnosis for those with cancer, and also to ensure that patients who don't have cancer do not wait and worry – in alignment with the national 28 day "Faster Diagnosis Standard (FDS)".

This is a really exciting project as patients will benefit from a significant investment in Harrogate aimed at improvements in early diagnosis and making cancers more curable. The project involves different work streams to deliver key parts. Led by radiology clinical lead for the project Dr Adam Culverwell, work has already begun on identifying gaps and opportunities for "timed cancer pathways". This will be followed by planning a new and improved diagnostic model, creating a referral pathway for patients with "vague symptoms" and establishing a Multi Diagnostic Centre (MDC) for this group of patients. Later this year the project will focus on Implementation of Faecal Immunochemical Test (FIT) for symptomatic bowel cancer patients across primary care.

The Transformation and Improvement team are facilitating a Rapid Process Improvement Workshop (RPIW) week commencing 30th July 2018. This five-day event supports the objectives of the Earlier Diagnosis Project. Bringing together a range of stakeholders, clinicians, cancer nurse specialists, general practitioners, staff in radiology, pathology, endoscopy, medical records, as well as service users, the workshop will strive to standardise process where appropriate and eliminate any unnecessary "waste" or inefficiencies within current practice. The event will enable participants to test and implement potential improvements during the course of the week and after.

Date of Meeting:	25 July 2018	Agenda item:	9.0								
Report to:	Trust Board of Directors										
Title:	Report of Director Workforce and Organisational Development										
Sponsoring Director:	Phillip Marshall, Director of Workforce and Organisational Development										
Author(s):	Phillip Marshall, Director of Workforce and Organisational Development										
Report Purpose:	<table border="1"> <tr> <td>Decision</td> <td>✓</td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<ul style="list-style-type: none"> • Significant reduction in sickness absence across the Trust in June 2018 • Arrangements are in place to implement the national pay award for Agenda for Change staff, including back pay • Medical job planning in clinical Directorates continues to be challenging 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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:	Health Education England and the Local Education and Training Board have access to the Trust's workforce data via the Electronic Staff Records system. Providing access to this data for these organisations is a mandatory requirement for the Trust.										
Resource:	Not applicable										
Impact Assessment:	Not applicable										
Conflicts of Interest:	None identified										
Reference documents:	Not applicable										
Assurance:	Report reviewed at Senior Management Team on 18 July 2018										
Action Required by the Board of Directors:											
<p>It is recommended that the Board:</p> <ul style="list-style-type: none"> • Notes items included within the report and comments where appropriate 											

Key messages for July 2018

a) Sickness Absence

The overall sickness absence rate across the Trust for May 2018 was 4.10% which is a decrease from April of 0.13% and continues a steady decrease in the absence rates each month from January 2018. The rate is currently 0.2% above the overall Trust target of 3.90%.

Looking at the overall sickness absence rate and the split between short- and long-term absence for May, short-term sickness was 2.04% and long-term sickness is 2.06%. There has been a decrease in absence rates across three of the Directorates, including Corporate Services at 1.67% compared with 1.89% in April, Children's and Countrywide at 4.56% compared with 4.75% in April and Long-Term and Unscheduled Care 4.44% compared with 4.59% in April. The sickness absence rate in Planned and Surgical Care has increased slightly to 4.18% compared with 4.15% in April. The main reasons for short-term absence remain cold and flu, and gastro issues, and the top reasons for long-term sickness are anxiety/stress and MSK.

As a Trust there is high focus on absence rates. Meetings are being held on a monthly basis with Directorate management at a number of levels to identify monthly hot spot areas; targeted activity can then take place to proactively support these areas including looking at top reasons for absence. We have started reviewing current absence processes to streamline activities involved in absence management and this revised paperwork will be made available for managers by the end of July. We are utilising feedback from managers to identify where improvements can be made in the absence policy to help the overall aim in supporting a reduction in absence. A paper looking at other effective changes to sickness absence management that could potentially be implemented will be considered in mid-July by the Workforce and Organisational Development Steering Group.

The provisional sickness absence figure for the Trust for June 2018 is 3.91%, which is a decrease from May of 0.19% and continues to follow the downward trend which started in January 2018. The overall rate, if confirmed, is just 0.01% above the overall Trust target of 3.90%. In comparison with June 2017, for which the figure was 4.08%, this year the rate is significantly lower.

b) Agenda for Change Pay Award

In the November 2017 Budget, the Chancellor stated that additional funding for a pay award to Agenda for Change staff could be made available dependent on successful talks on pay structure modernisation to improve recruitment and retention.

NHS Employers subsequently had constructive discussions with the trade unions and built an agreement that would meet the Chancellor's requirements for releasing additional funding (above the 1 per cent already funded for 2018/19), with the possibility of a multi-year pay deal. The agreement included:

:

- development of a new pay structure with a simplified number of increments
- the journey for staff through any new pay structure and how this links to their development and contribution
- aligning aspects of terms and conditions across staff groups and pay bands to any new pay structure.

Throughout the discussions, and in the evidence given to the 2018/19 NHS pay review body (NHS PRB), NHS Employers was clear that any changes to pay will need to be fully funded by the Government.

The agreement was then subject to extensive consultation by the trades unions, with a deadline of 31 May 2018. The staff side of the NHS Staff Council met on 8 June to discuss the results of the trade union consultations on the proposed deal; staff and the staff side of the NHS Staff Council decided to accept the proposed deal. All trade unions voted in support of the proposed deal with the exception of GMB.

The full NHS Staff Council ratified the deal on 27 June 2018. The agreement introduces a three-year, fully-funded pay deal, as well as the reform of the pay structure and changes to Terms and Conditions. The new pay structure will increase starting salaries, reduce the number of pay points and, for most staff, reduce the time it takes to reach the top of the pay band. From 2018/2019, funding for the pay deal will apply to existing and new staff on the NHS Terms and Conditions of Service (Agenda for Change) employment contract employed in both NHS bodies and non-statutory non-NHS organisations that provide NHS services. Moving forward, this funding forms part of the additional investment announced by the Prime Minister for the NHS; final confirmation is awaited from the Department of Health and Social Care and NHS Improvement as to how this money will be distributed to organisations.

Staff will be paid the new rates of pay in their July pay and, where appropriate, pay will be backdated to 1 April 2018; backdated payments for those eligible will be made in August's pay. Full details of the changes are available on the NHS Employers website. These include pay calculators and diagrams showing how transition between the existing pay structure and the new structure will take place. The Living Wage supplement paid by the Trust as a discretionary addition to the pay of those in the Lowest Band(s) will now be discontinued as the new rates of pay exceed the level of the Living Wage.

NHS Employers will be publishing resources over the next few weeks to assist the Trust in the implementation of the deal and a revised Terms and Conditions handbook will be published, alongside pay and terms and conditions advisory notices. Staff will be updated when further information is available.

c) Medical Occupancy Report 2018 – Yorkshire and the Humber

Health Education England (HEE) exists to help improve the quality of care by ensuring our workforce has the right numbers, skills, values, and behaviours to meet the needs of patients. HEE's main way of achieving this goal has been the planning and development of the future workforce supply through investment in high quality education and training.

The historic lack of connection between service strategy and workforce planning has been identified by HEE as one of the system's key challenges. The publication of the Five Year Forward View provided a clear overall vision of the radical changes to service delivery and ways of working that will be required to deliver an NHS that can deliver the triple aims of health, quality and financial sustainability.

Whilst a predominant driver has been an understanding of future workforce supply it is recognised that two further challenges need to be addressed - service and workforce transformation and current workforce capacity and supply. The number and locations of postgraduate medical trainees has an impact, not only on the current medical workforce capacity, but also the future workforce supply. This report, the first of its kind in Yorkshire and Humber seeks to identify the numbers and locations of placements that are occupied at a

given time point. Analyses were performed on 1 October 2016, 1 April 2017 and 1 October 2017 then 1 April 2018 in order to demonstrate not only the current status of trainee placements filled, but also the trend over time. It looks at recruitment fill rates and shows a specialty breakdown for each Trust as well as more detailed information which allows comparison with the position in other Trusts in Yorkshire and Humber.

d) Job Planning

JUNE 2018 JOB PLANNING CENTRAL REPORT - CONSULTANTS										
Directorate	Number of Consultants	Current Job Plans (ie < 12 months)	%	Job Plans older than 12 months	%	Number of Consultant with no Job Plans recorded	%	In progress	Previous month current JPs	RAG
C & CWCC	12	11	91.67%	1	0.00%	0	0.00%	0	100.00%	
LT & UC	57	48	84.21%	8	14.03%	1	1.75%	2	87.27%	
P & SC	66	30	45.45%	34	51.51%	2	3.03%	2	53.03%	
Total	135	89	65.93%	43	31.85%	3	2.22%	4	71.43%	

JUNE 2018 JOB PLANNING CENTRAL REPORT - SAS GRADES										
Directorate	Number of SAS Doctors	Current Job Plans (ie < 12 months)	%	Job Plans older than 12 months	%	Number of SAS Doctors with no Job Plans recorded	%	In progress	Previous month current JPs	RAG
C & CWCC	6	2	33.33%	4	66.67%	0	0.00%	0	33%	
LT & UC	12	5	41.66%	7	58.33%	0	0.00%	0	50.00%	
P & SC	41	16	39.02%	5	12.20%	20	48.78%	1	38.88%	
Total	59	23	38.98%	16	27.12%	20	33.89%	1	40.35%	

Excludes locums, maternity leave, bank; new starters u/6 months	Change from previous month (current JPs)	Improved	No change	Worse
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The June job planning figures (shown above) show a significant downturn in the rate of completed consultant job plans across all three Directorates. This shows that another concerted effort by the Directorate teams must be invested in finalising Job Plans with both Consultants and SAS doctors. In Planned and Surgical Care at least one specialty has recently concluded a review and revised Job Plans for doctors in that speciality are under active discussion, which may improve their overall rate during July, building on the Directorate's marginal improvement in June. It is hoped that agreement on a revised Job Planning Policy can be achieved at the meeting of the Local Negotiating Committee in September.

e) WYAAT Collaborative Medical Bank Steering Group

At the recent meeting of the Group it was agreed that work should begin with the Chief Operating Officers/Directors of Strategy on the development of break glass criteria that will govern escalation of bank rates beyond an agreed base level. Human Resource Directors were supportive of trialling an aligned rate card (similar to the one based on Leeds Teaching Hospital Trust rates) and monitoring both the compliance and the impact. However, it was also noted that feedback from both Finance and Medical Directors suggested that they would like to see an increased data collection (over and above the detailed analysis for one week in November). As a result it was agreed that a larger sample should be collected in order to establish an improved baseline including qualitative information. This would provide greater understanding of the reasons for escalation and variation in bank fill rates. The sample period will now run over a four week period, concurrently with development of escalation criteria and data.

It was also agreed that remuneration for waiting list activity is a potential candidate for collaborative work but is out of scope for this particular project. All WYAAT organisations agreed to standardise their unsocial hours window to be from 7pm – 7am. Finally it was acknowledged that there is some nervousness in the system about eventual progression to a

collaborative bank from the perspective of the potential for a disproportionate impact on one or more organisations.

f) Expansion of the Reporting Radiographer Workforce

As part of the NHS National Cancer Plan for England, HEE is providing support for an increase of up to 300 Reporting Radiographers over the next two years. Working with Cancer Alliances, HEE is offering employers an opportunity to upskill their reporting radiography workforce specifically to develop capability in image interpretation, and reporting, through the award of a Postgraduate Certificate, or Postgraduate Diploma, and integration of their new skills into local service provision. It is expected that Reporting Radiographers will work within the Radiology reporting team.

The aim of the scheme is to increase radiographer reporting capacity and support will only be provided where the impact of additional reporting capacity and/or release of radiologist reporting time can be demonstrated. Participants must be existing senior radiographers working in an NHS institution in England; they must have the support of their local Clinical Imaging Service Manager and Clinical Director; they must meet the entry requirements for postgraduate study at the chosen Higher Education Institution and their training (and subsequent practice) must address an identified service need.

HEE is offering financial support, which will require an employer contribution. Following completion, the participant will be expected to demonstrate capability in image interpretation and reporting through the integration of their new skills into local service provision. Continued clinical and academic progression will be important to support the development of expertise and enable reporting radiographers benefitting from this scheme to fully participate in MDT care, leadership and research roles and achieve professional accreditation as advanced or consultant practitioners.

The potential for Trust staff to take up this opportunity is under consideration.

g) West Yorkshire and Harrogate Excellence Centre Events

The West Yorkshire & Harrogate Excellence Centre is jointly hosted by Leeds Teaching Hospitals NHS Trust and Bradford District Care NHS Foundation Trust. This Excellence Centre brings together different organisations to coordinate and improve quality of training and is designed to coordinate and implement high quality skills programmes for support workers.

Firstly, the Excellence Centre is holding a one day themed conference, which is targeted specifically at support staff who work in health and care organisations across West Yorkshire and Harrogate and a small number of managers from member organisations. The theme of the event is "Training & Developing Support Staff" and the day, free to attend for staff, will provide delegates with personal development opportunities. It is scheduled to take place on 18 October 2018 at Victoria Hall, Shipley, Bradford, West Yorkshire. Refreshments and a Buffet Lunch are provided.

The second event is a Deaf Awareness Workshop running on 9 August 2018 at Cedar Court Hotel in Harrogate. This interactive workshop will be delivered by colleagues from a national charity Action on Hearing Loss and aims to get participants to consider what impact hearing loss can have on their health & wellbeing. The delegates attending the session will gain useful knowledge that will help them when to provide person-centred care when they are working with individuals who are experiencing hearing loss.

As a result of attending this workshop there will be an opportunity for those who are inspired to volunteer to become a Hearing Loss Champion. This development opportunity will involve

volunteers in awareness activities such as delivering the Impact of Hearing Loss workshops for others across their organisation; and providing basic hearing tests for the public.

h) Flu Campaign 2018-19

A detailed plan is in place for the 2018-19 flu vaccination campaign. Directorates have been tasked with the identification of Peer Vaccinators, who will each undergo appropriate training prior to the start of the vaccination campaign in late September/early October 2018. There will be significant emphasis placed on maximising uptake of vaccinations during the first two months of the campaign. Drawing on the experience in previous years, an updated programme to cover Trust staff in the community will be in place.

i) Expansion of the Clinical Endoscopy workforce

As part of the NHS National Cancer Plan for England, HEE is providing support for an additional 200 clinical endoscopists over the next two years through the HEE accelerated (7 month) clinical endoscopist training programme to support an increase in capacity for earlier diagnosis by 2021. The programme is funded by HEE, including a contribution to essential travel and overnight subsistence costs.

HEE is also providing a training support package of £15,000 per NHS trainee for the September and December 2018 cohorts. This package can be used to support creating sufficient capacity to release trainees from their duties or to provide training capacity when completing the 200 practical procedures within the Trust.

The programme is suitable for either registered nurses and/or HCPC registered healthcare professionals. Training will provide competence in either upper gastrointestinal (GI) endoscopy or flexible sigmoidoscopy, so successful individuals will be able to perform safe diagnostic procedures. Which technique candidates are trained in would be determined by the Trust.

As with the Reporting Radiographer programme, the potential for Trust staff to take up this opportunity is under consideration.

j) Handover in Medical and Surgical Specialities

There is a longstanding action from a Health Education England (Yorkshire and Humber) Quality Assurance of Local Education and Training Providers report concerning the consistency and robustness of handover practices in both medical and surgical specialities. The delay in the introduction of Web V has frustrated possible solutions. The Director of Medical Education will bring an update report to August's SMT meeting.

k) Workforce Efficiency Group

The Workforce Efficiency Group continues to meet fortnightly to focus on the reduction of costs associated with the employment of the Trust's temporary workforce. Significant attention has been given to the arrangements in the Trust for rostering and the engagement of additional staff. Focus has also been placed on the Trust's plans to address the national staff workforce shortages as well as local positions which are difficult to fill.

I) And finally.....

On a personal note this will be my last formal meeting of the Board of Directors before I leave the Trust in early September after 12 years in this role. It has been an excellent and very rewarding period of employment, made all the more enjoyable by working with successive groups of talented colleagues. There have been highlights and, inevitably, some low points, but overall it has been a wonderful experience and I thank Board colleagues, Chief Executives and Chairmen – past and present – for their support and wish them, and the Trust, well in the future.

P Marshall

Director of Workforce and Organisational Development

July 2018

Date of Meeting:	25 July 2018	Agenda item:	10.0								
Report to:	Board of Directors										
Title:	Chief Nurse Report										
Sponsoring Director:	Jill Foster										
Author(s):	Jill Foster										
Report Purpose:	<table border="1"> <tr> <td>Decision</td><td>✓</td> <td>Discussion/ Consultation</td><td>✓</td> <td>Assurance</td><td>✓</td> <td>Information</td><td>✓</td> </tr> </table>			Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<ul style="list-style-type: none"> The risk remains high regarding Registered Nurse vacancies on in-patient wards. Nurse recruitment and retention initiatives continue to show a challenging but improving position. The actions being undertaken to maintain safe staffing levels, quality of care and reduce cost. The new formats for Directors Inspections and Safety Visits The total number of category 2, 3 and unstageable pressure ulcers in the hospital and community pressure have remained about the same in June. The total number of falls has significantly decreased in June. The outcomes from participating in the NHSi Collaborative to improve Enhanced Care. County Durham 0 – 19 Children's Service has achieved UNICEF Baby Friendly Standards at Gold level. 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td><td>✓</td> <td>To work with partners to deliver integrated care:</td><td>✓</td> <td>To ensure clinical and financial sustainability:</td><td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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; BAF 3: risk of failure to learn from feedback and incidents 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:											
<ul style="list-style-type: none"> Be assured by the work being undertaken to improve of nurse recruitment and retention and the governance process for assuring safe staffing levels Be informed of actions being undertaken to maintain safe staffing levels, quality of care and reduce cost. Approve the new formats for Director Inspections and Safety Visits Note community and hospital acquired pressure ulcers in month are about the same Note the work around falls reduction Be assured about the monitoring of care provided by the CCT's Be informed about the outcomes and next steps for the work with the NHSi Collaborative to improve Enhanced Care. Note the achievement of County Durham 0 -19 Children's Service 											

The Chief Nurse report provides an overview of care quality, activities underpinning care and assurances on staffing arrangements. More details on key performance metrics are provided in the Integrated Board Report.

Patient Safety

1. Nurse Recruitment

As the Board is aware there are thousands of Registered Nurse (RN) Vacancies across England. Nationally demand for qualified nurses is likely to exceed supply for the foreseeable future. In these challenging conditions the registered nurse vacancies in the in-patient areas at HDFT is one of the highest risks on the Corporate Risk Register. The Trust has developed a continuing, innovative approach to recruitment and retention in mitigation of these severe challenges.

1.1 The Trust's recruitment and retention working group continues to work toward zero vacancies. Services and departments are continuously recruiting. The next recruitment event is planned for 19th July 2018.

1.2 In May Long Term and Unscheduled Care (LTUC) had **18.66** RN Band 5 vacancies across their inpatient areas, in June there are **17.71** RN Band 5 vacancies. In May LTUC had **3.36** Care Support Worker (CSW) vacancies, in June they have **4.85**.

1.3 In May Planned and Surgical Care (PSC) had **11.07** RN Band 5 vacancies across their in-patient areas, in June they have **8.91**. In May PSC had **1.61** CSW vacancies, in June they have **-8.14**.

1.4 In Main Theatres there are **12.58** Band 5 vacancies in June, there were **12.58** vacancies in May.

1.5 Current Situation on Adult In-Patient Wards

Ward	Registered Nurses			CSW's		
	Est.	Vac.	%	Est.	Vac.	%
Acute Admissions Unit	24.27	-1.21	-5%	15.65	-0.11	-1%
Byland	18.04	1.58	9%	21.12	-1.09	-5%
Clinical Assessment Team	26.03	9.92	38%	18.22	-1.04	-6%
Granby	13.47	1.38	7%	12.51	0.11	1%
Jervaulx	18.04	2.76	15%	21.12	1.37	6%
Lascelles	11.76	-0.6	-5%	10.68	1.54	14%
Oakdale	27.05	4.54	17%	16.04	0.04	0%
Trinity	12.01	-0.66	-5%	13.27	4.03	30%
Total	150.65	17.71	%	128.61	4.85	4%
Farndale	14.92	3.39	23%	17.04	-0.14	7%
Wensleydale	17.74	2.61	15%	12.87	-5.82	-37%
Littondale	20.32	-1.07	-1%	12.04	-1.71	-14%
Nidderdale	20.32	2.53	12%	15.21	-0.93	-3%
Harlow	11.51	1.45	13%	3.46	0.46	13%
Total	84.81	8.91	11%	62.62	-8.14	-9%
Emergency Department	30.52	6.97	23%	8.25	0	0%
Community Care Teams	52.60	3.23	6%	33.0		over
Main Theatres	43.0	12.58	29%	-	-	-

ITU	31.53	2.0	6%	2.90	0	0%
Maternity Unit	66.73	0.78	1.16%	12.05	-0.45	-3.76%
Woodlands	19.20	1.46	8%	6.80	0.16	2%
SCBU	11.36	0.93	8%	2.0	0	0%

This chart shows the current ward establishments in whole time equivalents (WTE) and the number of vacancies by ward for registered nurses and care support workers.

A '-number (-1.21 on AMU for example) indicates an over establishment.

1.6 Is the situation improving?

The nursing vacancy situation has improved in June for the in-patient areas of LTUC and PSC.

In June 2018, the Band 5 vacancies in the Emergency Department and Main Theatres remain the same.

Vacancies in Maternity, Paediatrics and the CCT's in June 2018 remain the same.

1.7 As I reported last month the current number of vacancies means there are significant gaps in the planned rosters for the wards. On a daily basis we continue to take action to mitigate the risk due to staffing gaps by

- Maximising effective rostering
- All shifts out to NHSP and agencies within cap
- All shift gaps published at ward level
- Incentive scheme offered
- Staffing gaps reviewed daily and staff moved to minimise risk
- Bed closures where feasible.

1.8 The number of 'hours owed' to the Trust is decreasing.

1.9 Actions being undertaken by the Chief Nurse (CN) to maintain safe staffing levels, quality of care and reduce cost

- Daily scrutiny of numbers of beds that need to be open
- Staffing gaps reviewed daily
- Participation in NHSi Enhanced Care Collaborative
- On 6th May 2018 I met with the Ward and Department Managers, Matrons and Heads of Nursing (HoN's) and Midwifery to discuss the financial situation and what action needed to be taken to avoid an overspend in ward and department budgets.
- On 12th June 2018 I, again, met with the Ward and Department Managers, Matrons and Heads of Nursing (HoN's) and Midwifery to issue the challenge to 'Live within Budget'. I have since issued a communication to all ward and department teams.
- I am continuing to meet with all Ward and Department Managers with their Matrons, HoN's and Head of Midwifery to discuss their budgeted staffing
- I am to benchmark wards at HDFT with wards at organisations identified by NHSi to compare nurse staffing levels
- NHSi Nurse Staffing Review took place on 24th July 2018. I will update the Board with the verbal feedback.

Whilst there are a number of reasons why the wards are overspent there is particular concern about the use of staff over and above the planned staffing levels for enhanced or 1:1 care.

Below is a table comparing the average Trust fill rate for actual v planned staffing levels from April to June 2018.

2018	Day		Night		Care Hours Per Patient Day		
Trust Total	RN fill Rate	CSW fill Rate	RN fill rate	CSW fill rate	RN	CSW	Overall
April	94.0%	112.8%	97.3%	143.1%	4.60	3.50	8.10
May	96.2%	107.4%	97.8%	121.4%	5.15	3.49	8.64
June	95.2%	101.8%	98.7%	111.9%	5.17	3.33	8.50

1.10 Actual versus planned staffing levels for June are reported in Appendix One.

2. Unannounced Directors' Inspections and Patient Safety Visits

2.1 The current format for director inspections and patient safety visits has been reviewed to ensure they contribute maximum value and assurance. The Director team agreed some proposals which have been shared for comment with the Board Members, Clinical and Operational Directors. Comments received have now been taken into consideration in relation to both director inspections and patient safety visits and the new formats have been approved by the Senior Management Team on 18th July 2018.

The new formats are outlined below:

2.2 Director Inspections

The aim is to extend the oversight of these inspections to provide assurance regarding local compliance with CQC fundamental standards and readiness for CQC inspection. This will continue to include inspection of infection control arrangements and medication safety procedures against expected standards.

These will continue to be unannounced, with the visiting team comprising:

- Executive director;
- Specialist nurse IP&C;
- Matron for the area;
- Clinical or Operational director – perhaps of another directorate to provide some peer review.

The template for director inspections will be reviewed and amended to incorporate additional CQC key lines of enquiry and to provide additional assurance in relation to CQC inspection readiness.

The reason for proposing that non-executive directors no longer participate is that these visits will be very much focused on compliance with standards and therefore the visiting team needs to comprise staff who can most appropriately assess compliance, and those who will need to address areas of non-compliance.

2.3 Safety Visits

The aim is to assess, encourage and support the local safety culture – and will be called safety visits rather than patient safety visits. These will be more structured than previously to focus on things like values and behaviours within the team, and whether staff are encouraged to report

incidents in order to improve safety, use risk registers to record and manage risk, develop and share ideas and learning, speak up about concerns and engage with individual and team quality improvement.

These will continue to be planned with the ward / department manager, with the visiting team comprising:

- Executive Director;
- Non-executive Director;
- Deputy Director of Governance or Governance officer.

Directorates will continue to be asked to identify locations for a visit at the start of the planning cycle and can highlight any areas they think might benefit from a safety visit at any time.

We have drafted a template to structure the visits and capture key findings, and will consider the use of a staff feedback form that can be provided ahead of the visit.

There will be an opportunity during safety visits to speak with patients (in patient areas) and staff.

The reasons for proposing that governors no longer participate in these visits are:

1. We want to rationalise the number of people involved in safety visits; sometimes visits have been overwhelming for wards and teams.
2. The purpose is to assess and promote an organisational culture of safety and transparency, and this is not something that we should expect governors to be able to contribute to.
3. There are other more appropriate routes for governors to seek assurance and liaise with patients; e.g. quality of care teams and LPEG.

2.4 Next Steps

- To finalise the new templates to structure the Inspections/Safety Visits
- To arrange dates for the Inspections/Safety Visits

The Board is asked **to approve** the new formats for Director Inspections and Safety Visits

Patient Outcomes

3. Pressure Ulcer Target 2018/19

3.1 The pressure ulcer reduction target for 2018/19 continues to be to reduce the number of avoidable category 3, 4 and unstageable pressure ulcers to zero. In addition, I have challenged the teams to reduce the total number of hospital acquired pressure ulcers by 15%.

In January 2018 I reported there had been an increase in the number of community acquired category 3 and unstageable pressure ulcers particularly in Harrogate North and South CCT's. The numbers in February 2018 remained about the same. In March and April 2018 there was a reduction in category 3 and unstageable pressure ulcers across all the Community Care Teams. There has been an increase in May 2018 but a slight reduction in June 2018.

January 2018 also saw a rise in hospital acquired pressure ulcers categories 2-3 and unstageable. I was pleased to report the number of hospital acquired pressure ulcers categories 2-3 and unstageable was significantly lower in February 2018 but there was an increase in March 2018. There was a significant decrease of pressure ulcers (all categories) in April 2018. In May 2018 the number of category 2 hospital acquired pressure ulcer has increased but the number of

category 3 and unstageable is the same. In June 2018 the numbers are the same as May. There has been no category 3 or unstageable pressure ulcers in LTUC in May or June.

4. Falls

4.1 I am continuing to monitor the total number of falls per month and the number of falls resulting in fracture.

Falls	2017/18		2018/19	
	Total Falls	No of Fractures	Total Falls	No of Fractures
April	63	3	68	3
May	55	2	52	3
June	64	3	49	1

5. Quality of Care in the Community (Adult Community Care Teams in Harrogate)

5.1 Since December 2017 to date the Community Care Teams (CCT's) have been experiencing significant pressure. Demand on the service coupled with the teams' capacity has meant the community OPEL score daily, has fluctuated between 2 and 4. This continued throughout the first three months of 2018. In April 2018 the OPEL level fluctuated between 2 and 3. This has continued in May and June. Workload is reported as manageable.

The Directorate has been monitoring a number of proxy indicators for deterioration in the quality of care. These indicators include the total number of pressure ulcers and total number of avoidable pressure ulcers, end of life care issues, access to the service via the telephone and finally formal complaints.

In January 2018 I reported an increase in January in the number of category 3 and unstageable pressure ulcers particularly in Harrogate North and South CCT's and that 1 formal complaint had been received. The number of category 3 and unstageable pressure ulcers remained about the same in February 2018. In March and April 2018 the number of category 3 and unstageable pressure ulcers reduced across all the CCT's. There has been an increase of pressure ulcers in May 2018. The number in June 2018 remains the same as May. There have been no End of Care Life issues and no complaints received regarding the Community Care Teams since February 2018.

Patient Experience

6. Complaints

6.1 The number of complaints received in June 2018 is 13.

Of the complaints received in June 2018, 10 have been graded Yellow and 3 Green.

6.2 The number of complaints received by month, year to date (YTD) compared with the previous three years is shown below.

Total number of complaints by month for 2018/19 compared to the previous three years.													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
2018/19	15	24	13										
2017/18	16	21	16	11	22	16	20	14	14	26	8	26	209
2016/17	18	16	24	21	25	19	19	18	9	14	26	25	234
2015/16	26	18	30	15	17	26	11	9	12	12	21	16	213

7. NHSI Collaborative for Improving Enhanced Care

7.1 HDFT has participated in a 90 day NHSi Collaborative for Enhanced Care. This programme has now finished. There were three aims for joining the programme.

- To reduce the cost of providing enhanced, including 1:1 care.
- To improve the experience for patients receiving enhanced, including 1:1 care,
- To improve the experience of staff providing enhanced, including 1:1 care.

What has been achieved?

- A new robust Assessment Tool has been developed and piloted on Oakdale and Wensleydale. The tool has had a number of adjustments and has now been fully rolled out in LTUC the next steps are to

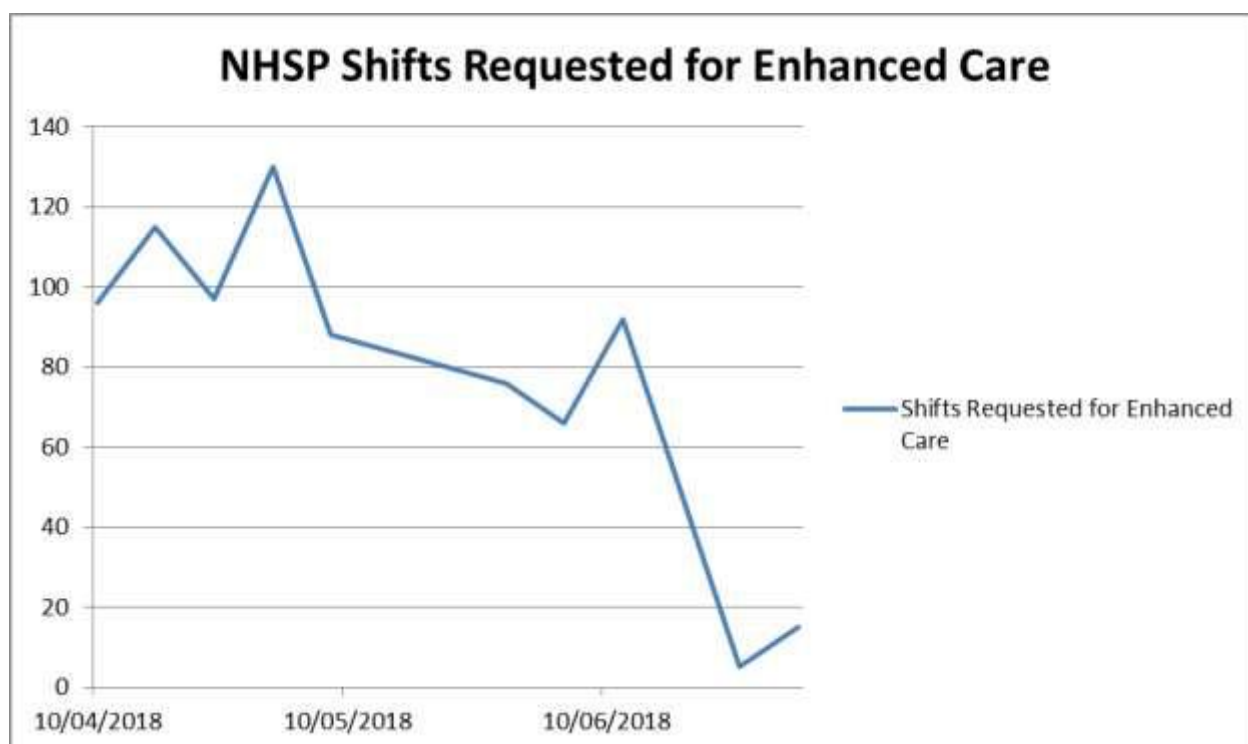
Agree the final version of the tool

Roll to tool out to all areas

Ensure the tool is fully understood and embedded in practice across the Trust

Update the 'Managing Challenging Behaviour' Policy

- All patients with additional supportive needs are reviewed every 24 hours or sooner
- The escalation process has been strengthened and all requests for additional or above planned staffing levels has to be approved by a Director. Since this has been implemented we have seen the number of requests reduce.



- Relatives have been involved in providing care on the pilot wards.
- CSW's on Wensleydale have developed an activity proforma for providing 1:1 care.

Next Steps

- To ensure the Risk Assessment Tool is used in all appropriate areas, is understood and embedded
- To ensure the escalation process is understood and embedded across the organisation.
- To participate in follow up calls with NHSi Regional Leads.
- To attend the follow up event in February 2019 to provide feedback on how our work has been scaled up across the organisation and sustained.

8. Baby Friendly Initiative

I am proud to inform the Board the County Durham 0 – 19 Children's Service has been awarded UNICEF Baby Friendly Status at Gold Standard. They are the sixth 0 – 19 Children's Service nationally to achieve this award.

Jill Foster
Chief Nurse
July 2018

Appendix One

Actual versus planned nurse staffing - Inpatient areas

The table below summarises the average fill rate on each ward during **June 2018**. 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 June was **8.50** care hours per patient per day.

	Jun-2018						
	Day		Night		Care hours per patient day (CHPPD)		
Ward name	Average fill rate - registered nurses/ midwives	Average fill rate - care staff	Average fill rate - registered nurses/ midwives	Average fill rate - care staff	Registered nurses/ midwives	Care Support Workers	Overall
AMU	98.9%	101.0%	100.0%	123.3%	4.48	2.94	7.42
Byland	90.4%	115.7%	93.6%	135.6%	2.76	4.24	7.00
CATT	92.1%	113.3%	93.3%	103.3%	5.09	3.38	8.48
Farndale	88.4%	92.2%	101.7%	105.0%	3.22	3.21	6.43
Granby	98.6%	119.2%	100.0%	101.7%	3.67	3.56	7.23
Harlow	103.3%	93.3%	100.0%	-	7.16	1.89	9.05
ITU/HDU	108.9%	-	109.3%	-	23.66	1.22	24.88
Jervaulx	93.0%	97.9%	92.0%	116.1%	2.70	3.34	6.03
Lascelles	101.5%	98.0%	100.0%	113.3%	4.64	4.27	8.91
Littondale	101.1%	121.3%	97.8%	121.7%	4.20	2.58	6.77
Maternity Wards	96.5%	91.7%	99.4%	85.0%	14.93	4.05	18.99
Nidderdale	100.4%	74.8%	108.1%	98.3%	3.55	2.89	6.44
Oakdale	86.2%	112.8%	92.5%	141.7%	4.19	3.23	7.42
Special Care Baby Unit	93.9%	25.9%	90.0%	-	12.83	0.96	13.79
Trinity	99.9%	86.0%	100.0%	100.0%	3.71	3.79	7.50
Wensleydale	94.7%	130.0%	100.0%	128.3%	3.42	2.81	6.23
Woodlands	76.4%	83.3%	96.7%	53.3%	10.36	2.48	12.84
Trust total	95.2%	101.8%	98.7%	111.9%	5.17	3.33	8.50

ED	97%	97%	101%	93%			
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Further information to support the June data

On the wards CATT, Byland, Jervaulx, Oakdale and Farndale, 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 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 care staff gaps were due to vacancies and sickness in June; 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 June this is reflected on the wards; AMU, Byland, CATT, Oakdale, Jervaulx, Granby and Wensleydale.

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

The staffing complement for the children's ward, Woodlands, is designed to reflect varying levels of occupancy. The day and night time RN and Care staff hours are less than planned in June 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.

ANNUAL INFECTION PREVENTION AND CONTROL REPORT 2017/2018

June 2018

You matter most

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2017/2018 summary

Month	CDI		MSSA BSI		MRSA BSI		<i>E. coli</i> BSI		Klebsiella BSI		<i>P. aeruginosa</i> BSI		Confirmed 'flu
	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	
April 2017	0	2	0	1	0	1	1	9	2	3	0	0	0
May	0	2	1	2	0	0	1	11	0	3	1	0	0
June	0	0	0	5	0	0	3	10	0	3	0	0	0
July	0	1	0	4	0	0	1	15	1	2	1	0	0
August	0	0	1	1	0	0	4	14	0	4	0	0	0
September	2	2	1	3	0	0	2	13	1	1	0	2	1
October	1	6	0	1	0	0	1	10	0	1	0	1	7
November	2	1	0	2	0	0	0	3	0	4	0	1	3
December	0	2	1	5	0	0	1	6	0	0	0	0	37
January 2018	0	2	0	4	0	0	0	15	0	2	0	1	73
February	1	2	0	3	0	0	0	14	0	3	0	0	34
March	1	1	1	4	0	0	0	12	0	1	0	1	35
Running total	7	21	5	35	0	1	14	132	4	27	2	6	190

C. difficile

The total number of Trust-apportioned CDI cases for 2017/2018 was seven, compared with 29 in 2016/2017 and 35 in 2015/2016. The annual objective of twelve or fewer cases was therefore achieved. Case 7 was deemed to be a lapse in care secondary to the use of cefuroxime in a patient with a previous history of *C. difficile*, which is disappointing, however, this was the only contributory lapse in care for the year.

According to the most recent YHFES report (October to December 2017), we are now right on the mean value for Trust apportioned CDI rates. The annual regional report, with rates, is usually published in July.

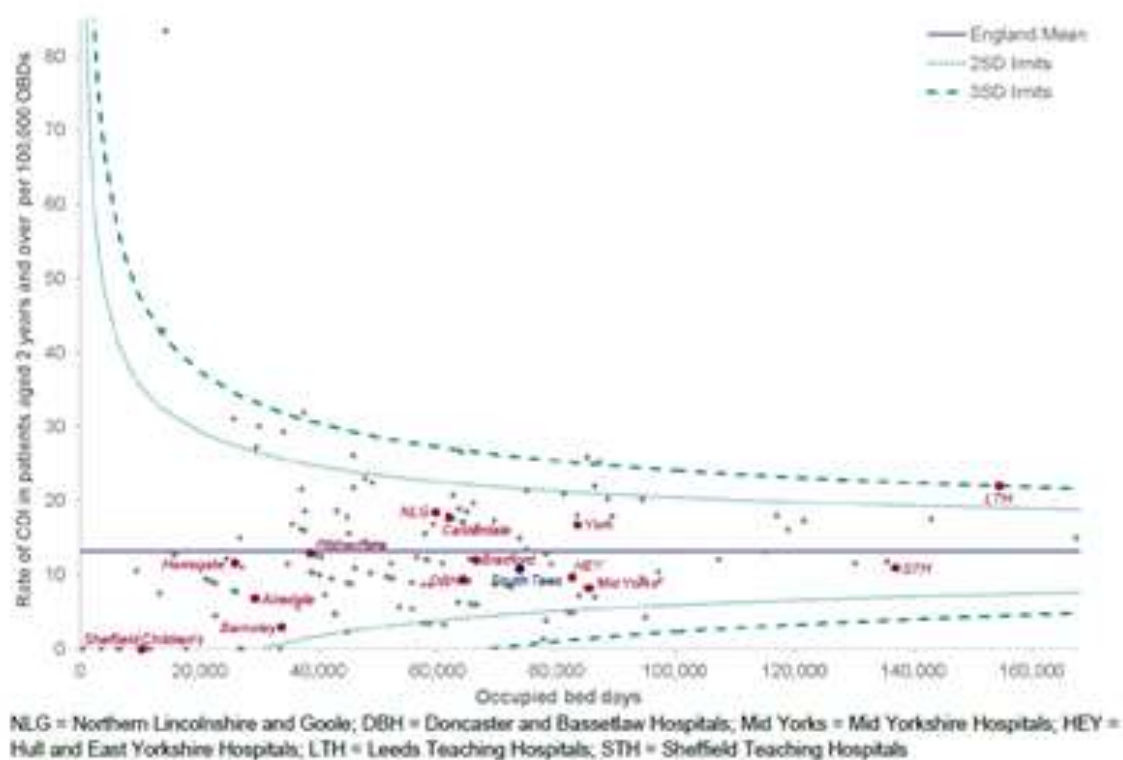


Figure 1: Trust-apportioned CDI rates in patients over 2 years of age per 100,000 bed days for all England acute trusts from October to December 2017

Source: YHFES Report Oct-Dec 2017, received March 2018 – HCAI Mandatory surveillance: Data points represent all acute NHS trust in England. Trusts within Yorkshire and Humber are highlighted in red. Dashed lines represent control limits at 2 and 3 standard deviations (SDs) around the national mean to allow identification of trust with significantly outlying rates.

The 2018/2019 annual objective has been set at eleven.

***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.

MRSA screening

Despite DoH recommendations to reduce the number of MRSA screens to those in high risk groups (such as trauma and orthopaedics, adult and neonatal critical care units, transfers in from other hospitals and previously known carriers), at HDFT, we have continued with universal screening.

In 2017/2018, we carried out 7630 MRSA screens on 8699 elective patients (87.1%) and 11081 screens on 12790 non-elective patients (86.4%). The positivity rate for MRSA screens is very low (<1%). Each screen costs £4.00 (laboratory consumables and BMS time only), representing a total outlay of at least £74,848 for the year, or £473.72 to pick up each positive.

In the coming year, we will be reviewing the MRSA screening strategy.

***E. coli* bacteraemias**

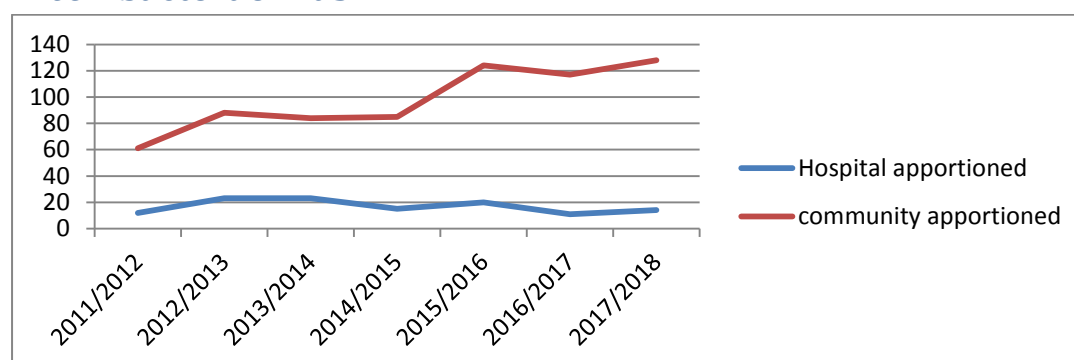


Figure 2: *E. coli* bacteraemias, April 2011-March 2018, HDFT

There was a slight increase in Trust apportioned *E. coli* BSI, from 11 in the previous year, to 14 this year. The total number is still low in comparison with many other Trusts. The community acquired *E. coli* BSI increased from 117 cases in 2016/2017 to 132 this year.

Of the total, 59 (41%) were thought to be secondary to a UTI, of which approximately two thirds were lower UTI. A majority of patients (115) had not had a urinary catheter in the 28 days before the bacteraemia. Only two *E. coli* bacteraemias were thought to have been secondary to a catheter associated UTI. A hepatobiliary infection was the second most common cause (32%); in 15% of cases, no underlying source was immediately obvious.

NHSI are demanding a 10% year on year reduction in *E. coli* BSI cases across the whole healthcare economy. For reasons that are not immediately obvious, the focus seems to be on the fraction that are hospital (here 11%) rather than community focused. We aim to:-

- Increase awareness about UTI prevention through work in residential homes and GP surgeries.
- Increase the awareness of the importance of hydration, particularly in the summer months.
- Look in more detail at the *E. coli* BSI which have a urinary focus, regardless of whether they were community or hospital onset.

Multiply-resistant organisms

Multiply-resistant Gram-negative bacilli

A recent report issued by the Yorkshire and Humber Epidemiology Unit (Jan-March 2018) stated that the number of resistant organisms in the region is rising, slowly but surely. In the January-March quarter of 2018, 14.7% of blood culture *E. coli* isolates were reported as being resistant to piperacillin-tazobactam (Tazocin). Three years ago, that figure was 9.5%.

ESBL (extended-spectrum B lactamases) and AmpC are enzymes produced by Gram-negative organisms which confer resistant to some extended spectrum penicillins and cephalosporins. The genes which control them are passed from strain to strain on extra-chromosomal mobile genetic elements which more often than not also confer genes to several other antibiotic classes.

The number of ESBL and AmpC producers in blood cultures has been rising sharply over recent years. We have every reason to think that this trend is likely to continue. NB the figures in Figure 3 include any Gram-negative rod. Some will be non-reportable organisms such as *Citrobacter* and *Proteus* spp. The increase in blood-culture isolates producing either ESBL or AmpC is interesting. Many of the bacteraemias will be secondary to urinary tract infections.

The number of urinary isolates producing ESBLs and AmpCs 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.

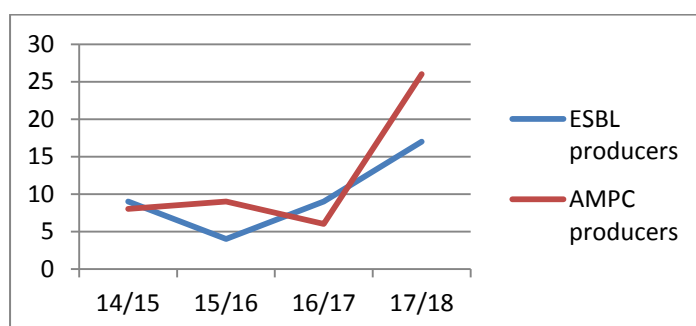


Figure 3: ESBL and AmpC producing organisms in blood cultures

Source: LabCentre, HDFT, courtesy of Lucy Jenkinson

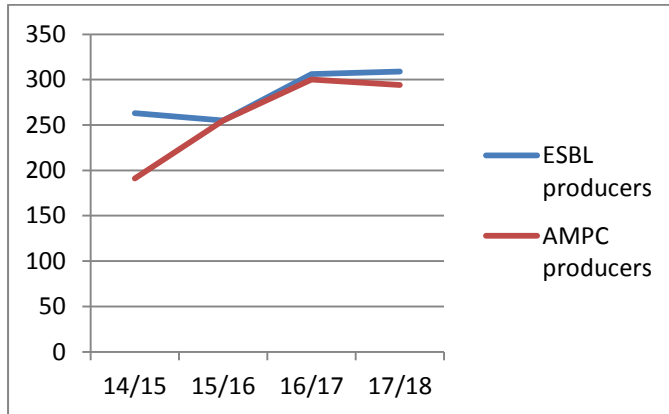


Figure 4: ESBL and AmpC producing organisms in urine specimens

Respiratory viruses

In November, we introduced a more streamlined respiratory virus policy which replaced several previous policies. The pandemic 'flu policy remains separate.

The winter of 2017/2018 was a particularly busy one for respiratory viruses, with nearly 200 cases on laboratory confirmed influenza alone. The last week of December 2017 and the month of January 2018 were especially busy. In addition, there were many cases of parainfluenza and RSV, in adults as well as children.

There were at least four main viruses circulating:

- Flu A (H3 seasonal; H1 "swine" flu; undifferentiated)
- 'Flu B
- RSV (data not shown)
- 'parainfluenza (September/October 2017, two of whom required ITU admission)

Figure 5 below, taken from a regional report, shows comparison with previous years.

It was unfortunate that in the 2017/2018 season, the trivalent vaccine which was given to staff and we believe to most patients vaccinated by their GPs, did not give good coverage for influenza B.

Laboratory Confirmations: Laboratory confirmed cases of respiratory infections by week

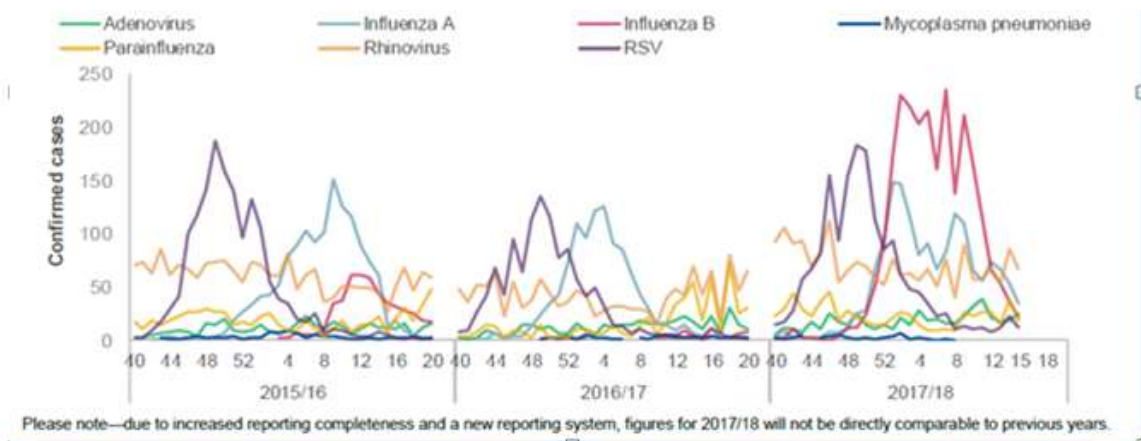


Figure 5: Local laboratory data for Yorkshire and Humber

Source: Public Health England (Yorkshire and Humber)

We had clusters on Byland, AMU, Jervaulx and Littondale.

The samples being sent off to Leeds were taking an average of three days for a positive, and five days (range 3-8 days) for a negative result, which were not telephoned through. The total processing time included the actual time taken at HDFT to send the specimen away and to manually validate the result and release it onto ICE. Negative results are as important as positive ones for making best use of side-rooms etc.

On the 19th January 2018, we introduced an in-house diagnostic testing using a rapid multiplex PCR system (GenMark) costing approximately £98 per test. The feedback from the IPCT and clinicians was overwhelmingly positive. Getting results back in a timely manner meant we were able to make better use of side rooms.

Dr Smith reported several patients who didn't get the antibiotics they might otherwise have done, and two patients who might otherwise have had a CTPA. The usefulness of this strategy was actually in shaping what we didn't then have to do as a consequence of making a positive diagnosis of a viral illness.

For the coming season, which usually starts at the end of September onwards, we intend to offer a similar in-house test. We are also looking into the feasibility of also introducing point of care testing for influenza and RSV in A&E and the new clinical assessment unit.

Decontamination report

Report title: Annual report of Decontamination Committee
Report to: Providing a Safe Environment Steering Group
Report author: Richard Hobson, Consultant Microbiologist
Date: March 2018

Objectives for 2017/18

- 1) Oversee the installation of the new AERs as part of the wider new extension and major refurbishment of the existing Sterile Services Department.
- 2) 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 (revised in July 2016).
- 3) To fulfil all best practice requirements with the recently released Health Technical Memorandum 01-06 (A-E): Policy and Management Decontamination of Flexible Endoscopes (revised in July 2016).
- 4) To ensure compliance to ISO16442:2015 – Controlled environment storage cabinet for processed thermolabile endoscopes.

Report of progress against the objectives

1. Oversee the installation of the new automated endoscope reprocessors (AERs) as part of the wider new extension and major refurbishment of the existing Sterile Services Department (SSD)

This objective has been completed. The AERs are fully operational in the new Sterile Services Department.

2. 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 (revised in July 2016).

This objective has not yet been completed.

It has been demonstrated that the protein detection system works with the chemicals currently available. However, a decision needs to be made as to how frequently protein testing needs to be done. The HTM does not make it clear which of its recommendations are mandatory and which are aspirational. Due to the lack of clarity advice is being sought from the Trust AE (D) about the use and frequency of carrying out these tests. Recommendations will be put to the Decontamination Committee for approval.

This objective will be carried over to 2018/19 with the aim of establishing frequency and testing parameters and introducing this in to regular practice.

3. To fulfil all best practice requirements with the recently released Health Technical Memorandum 01-06 (A-E): Policy and Management Decontamination of Flexible Endoscopes (revised in July 2016).

This objective has been completed. The audit was carried out on the 29th November 2017 where the Notified Body, British Standards Institute stated the requirements of ISO 13485:2016 (which includes compliance to HTM 01-06) had been fully and effectively implemented.

4. To ensure compliance to ISO16442:2015 – Controlled environment storage cabinet for processed thermolabile endoscopes

This objective has not been completed because of the concentrated work involved with the SSD and EWD centralisation process (objective number 1). The item will be carried over into the objectives for 2018/19.

Terms of Reference

Revised terms of reference were agreed in January 2018. Only minor changes were made, which reflected changes in the services provided by HDFT and a realignment of some of the staff who attend the committee with their named roles.

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 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.

Decontamination Report Appendix 1: Attendance monitoring

Membership	Meetings				Total	%
	29/03/17	28/06/17	04/10/2017	31/01/2018		
Consultant Microbiologist	✓	✓	✓	✓	4	100
Head of Decontamination Services	✓	✓	✓	✓	4	100
AP (D)	✓	✓	✓	✓	4	100
HIPCN	✓	✓	✓	✓	4	100
CIPCN	✓			✓	3	75
Deputy Manager Decontamination Services					1	25
Sister, Surgical Outpatients	✓	✓	✓ (Rep)		3	75
Manager, Endoscopy			✓		1	25
CIA representative		✓				25
Decontamination Link, Endoscopy						
Head of Community Equipment Service						
Sister, ENT						
Theatres/Critical Care/DSU Representative				✓✓✓	1	25
Director of Performance and Delivery						
Domestic Services Manager						
AE (D)	✓		✓		2	50
Medical Device Safety Officer	✓	✓	✓	✓	4	100
Deputy Director of Estates						
Quality Production Services Manager (Added to membership Dec 2016 at MD's request)				✓	1	25
Quoracy: Total members per meeting Quorum (8)	9	7	8	10		

Cleaning

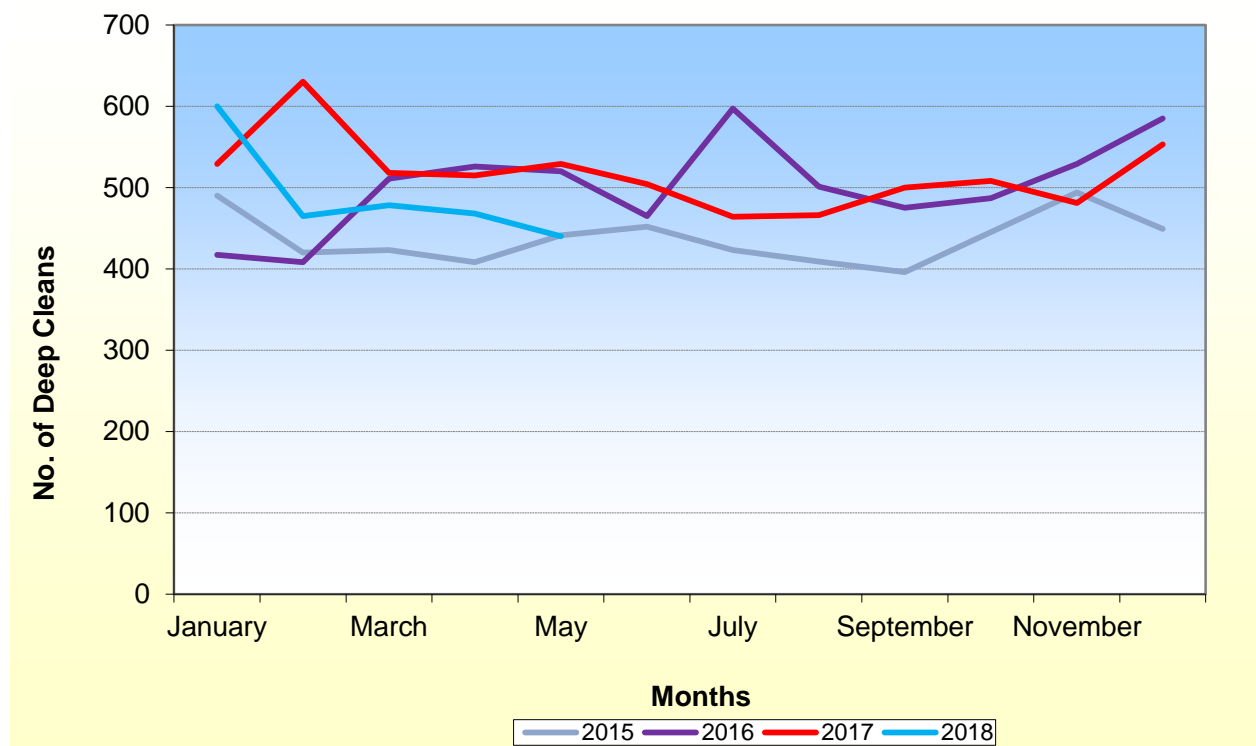


Figure 6: Deep cleans undertaken by Domestic Services, 2015- current

Source: Stuart Kelly

The environment is increasingly recognised as having a crucial role in the transmission of infectious agents in a hospital setting. Cleaning the environment properly is fundamental to minimising the spread of multiply-resistant organisms, *C. difficile* spores and some viruses within the environment.

The number of deep cleans has increased - in 2017, there were nearly 1,000 more deep cleans than in 2015, representing an overall increase of 18% between the two years.

We have replaced our old Bioquell HPV machines with two new ones, (Deprox) from Hygiene Solutions, which seem to be working well. The company loaned us a UVC machine free of charge as part of the deal, but regrettably, we were not able to make as much use of them as we'd hoped to. The planned rolling deep clean was abandoned.

Antimicrobial usage

The overall antimicrobial usage remains low in comparison with other Trusts in the region.

The prescribing of co-amoxiclav has remained low, but prescriptions of the cephalosporins and extended spectrum penicillins have risen slowly over time.

Filter Summary

Drugs: ATC: J01 - ANTIBACTERIALS FOR SYSTEMIC USE. **Specialties:** CQUIN Preset (223 of 229). **Prescription Types:** All

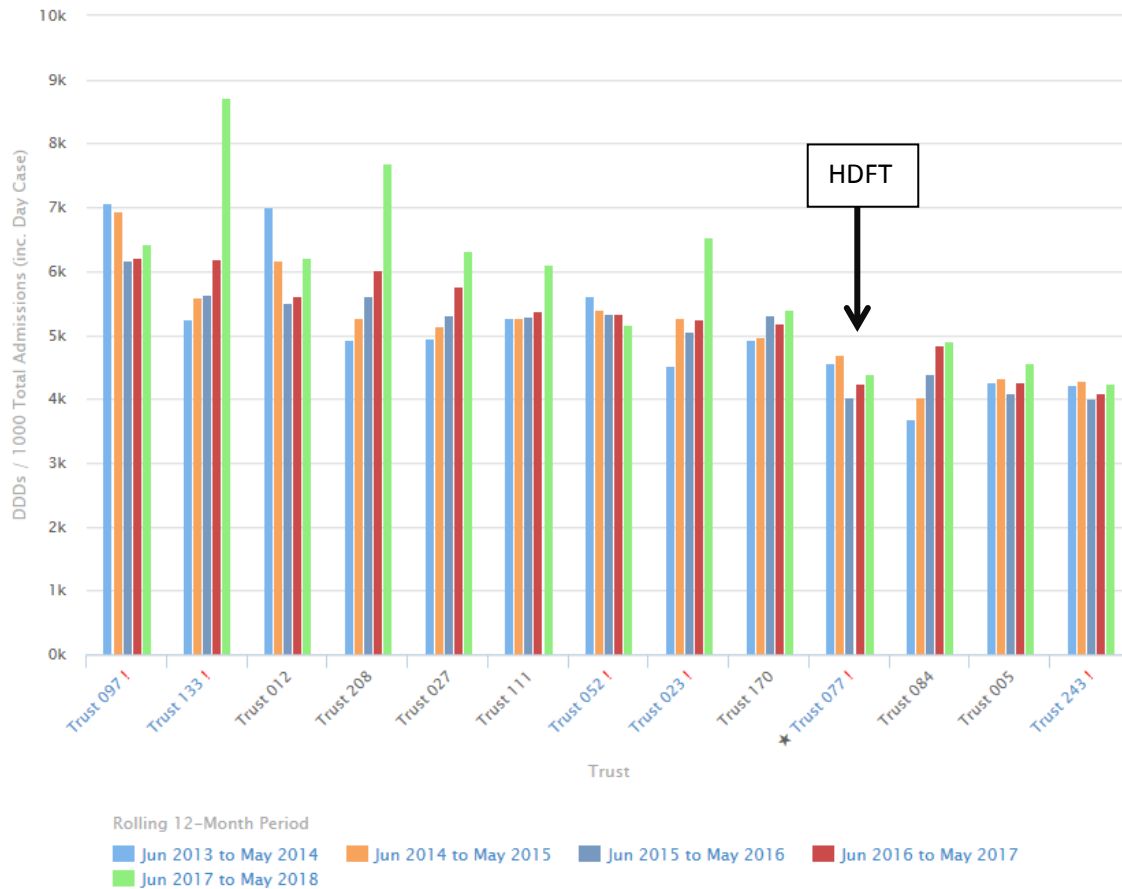


Figure 7: Antimicrobial prescribing, Y&H, June 2013-May 2018

Prescribing of individual agents

(NB scales on vertical axes are different!)

DDD- defined daily dose

OBD- occupied bed days

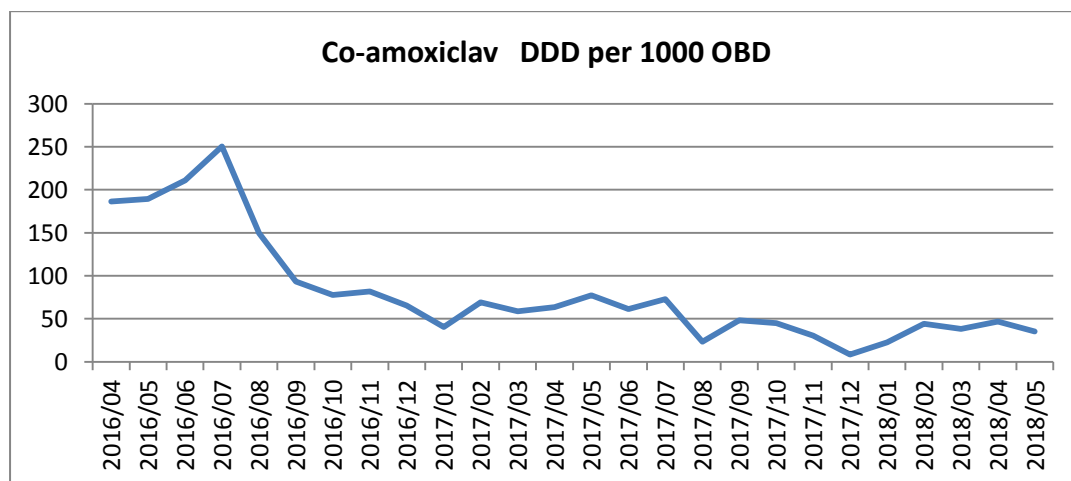


Figure 8: Prescribing trend for co-amoxiclav, April 2014- current, HDFT

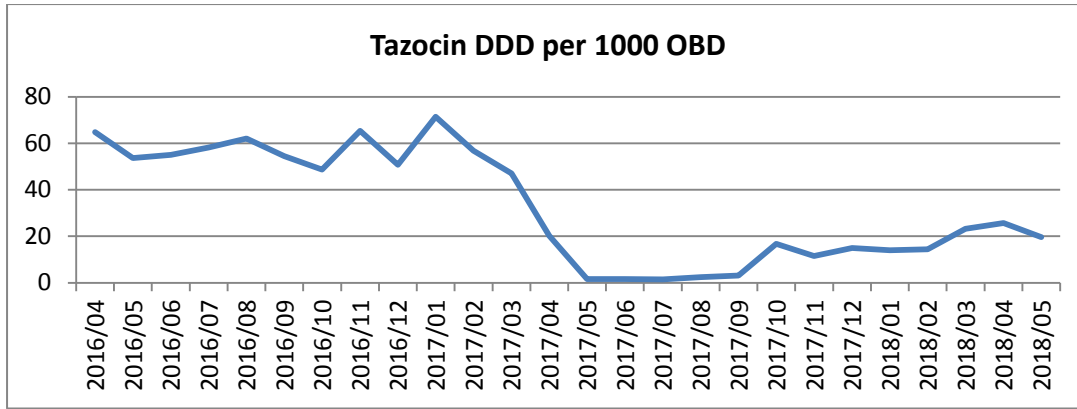


Figure 9: Prescribing trend for piperacillin/tazobactam (Tazocin), April 2014- current, HDFT

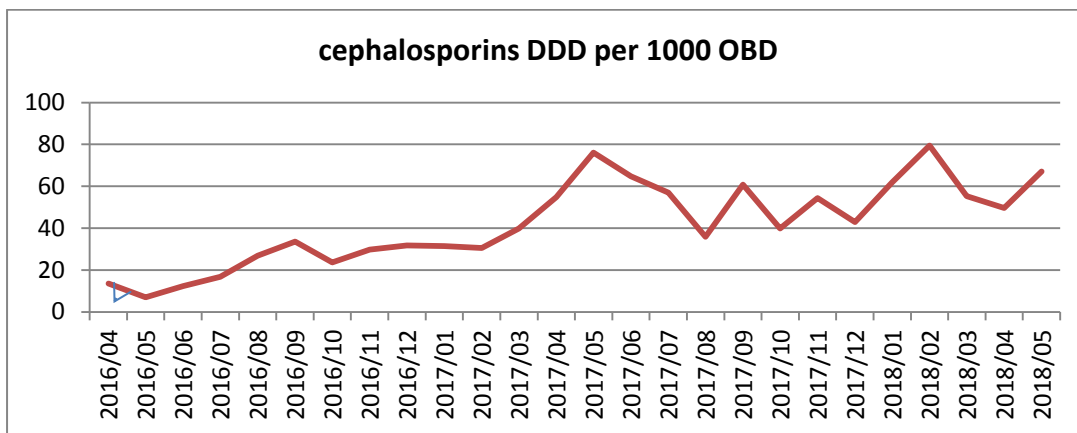


Figure 10: Prescribing trend for the cephalosporins, April 2014- current, HDFT

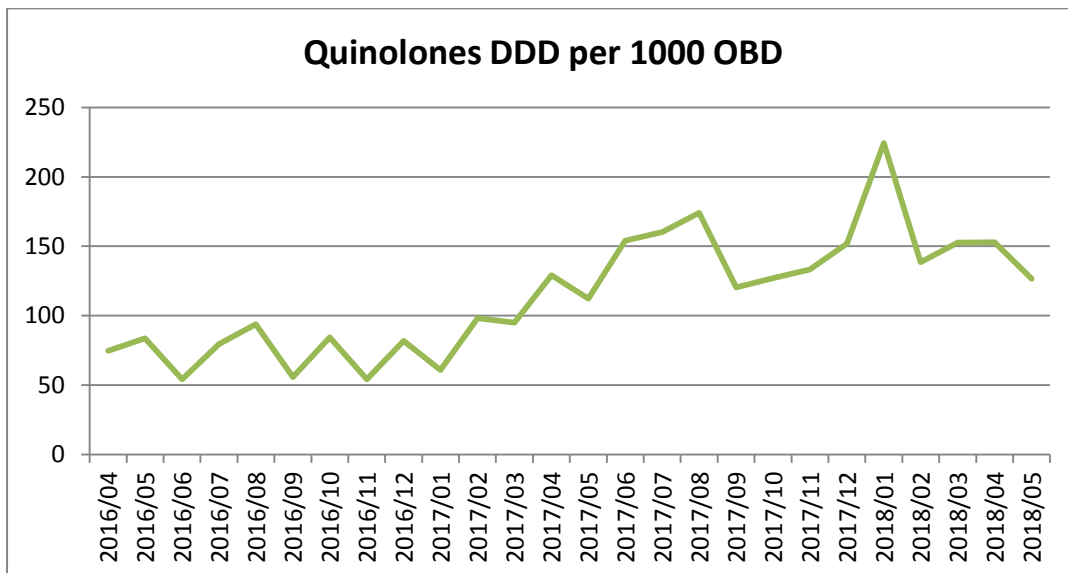


Figure 11: Prescribing trend for the quinolones, April 2014- current (HDFT)

Quinolones include ciprofloxacin and levofloxacin. The increase in early 2018 is a reflection of the number of respiratory tract infections at the time.

Quality improvement for surgical teams (QIST) initiative

HDFT has joined the QIST study, an initiative headed by Northumbria Healthcare NHS Foundation Trust, aiming to reduce the number of MSSA infections after primary hip and knee replacements.

The two arms of the study include

1. Infection- all patients undergoing primary hip and knee replacements to be given Octenisan body wash, with an option to screen all patients for MSSA and decolonise carriers, or to give all patients nasal decolonisation. We have decided to do the latter.
2. Optimising haemoglobin pre-op, with iron supplements or transfusion.

Prosthetic joint infections are the most expensive to treat in terms of length of stay, the need for revision operations and long antibiotic courses. A typical episode costs ~£22,000. The impact on patients' lives is considerable.

In summary

This has been a good year for Infection Prevention and Control. The number of CDI cases has remained lower than in previous years. The winter was particularly challenging, mainly because of the large increase in patients presenting with respiratory infections, mostly viral. The organisation coped remarkably well, and the introduction of a new diagnostic platform at three weeks' notice mid-season made a difficult situation much easier to manage from an infection control and patient management point of view.

The challenges for the coming year will be keeping the CDI numbers low, and maintaining a tight control on the rising multiply-resistant Gram-negative organisms.

Progress against infection prevention and control service annual work plan 2017/18

Monitored by: Hospital and Community Infection Prevention and Control Team meeting

Reports to: Trust wide Infection Prevention & Control Committee

Report authors: Kath Banfield, Amanda Gooch & Sonya Ashworth

Date: April 2017 – April 2018

Operational and Responsible Leads:

SA – Sonya Ashworth

KB – Kath Banfield

SC – Sarah Chadwick

JC – Jenny Child

CG – Caroline Gent

AG – Amanda Gooch

IG – Iona Goodwin

AZ – Alexia Zeniou

RH – Richard Hobson

WH – Ward Hygienist

GJ – Gillian Johnson

JM – Jessica Martin

GM – Gillian Mitchell

AP – Anna Padget

CR – Christopher Richardson

Infection Prevention and Control Annual Work Plan 2017/18

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/18
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	Annual Infection Prevention and Control Time Out	KB	JC	Dec-17	Green
			Bi-monthly Quality of Care Team meetings	KB	JC	Mar-18	Green
			Evaluate effectiveness of HIPC AND CIPC service through user surveys	AG & SA	KB	Mar-18	Amber Green - community
			Review and revise IPCN On-Call Service	AG & SA	KB	Mar-18	Green
			Implement SystmOne to improve information exchange to/from CIPCT	SA	KB	Aug-17	Green
			Confirm timescale for WebV IPC module for HIPCT	AG	KB	Mar-18	Amber
			Continually review and revise IPC working systems and staffing establishment to ensure effective use of resources and achieve cost improvement target	AG & SA	KB	Mar-18	Green
			Undertake Gram-negative bacteraemia gap analysis to formulate a Plan to reduce Gram-negative bacteraemia cases. Work collaboratively with CCG key stakeholders, Continence Team, Urology Nurses and others to deliver this plan.	KB	JC	Mar-18	Green
2	Revise IPC Policies to cover HDFT hospital and community services. Revise Community IPC Policies for Health and Social Care	Publication of updated policies	Revise section 001 Management and Organisation to reflect review of HCAI Governance arrangements	KB	JC	Dec-17	Green
			Revise section 002 Isolation Principles	AG	JC	Sep-17	Green
			Revise section 008 Chicken Pox and Shingles	RH	JC	Jun-17	Green
			Upload revised section 017 Exclusion of Staff to intranet	CR	AG	Jun-17	Green
			Revise section 012 MRSA screening policy	JC	JC	Oct-17	Amber
			Revise section 014 Standard Precautions	IG	JC	Jan-18	Green
			Revise section 018 MRGNB	JM	JC	Mar-18	Green
			Revise section 019 Decontamination	RH	JC	Jul-17	Green
			Integrate section 023 Waste and Facilities Waste Policy	JC	JC	Jun-17	Green
			Integrate section 030 Legionella and Facilities Legionella Policy	JC	JC	Jun-17	Green

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/18
			Revise section 032 Visitors	IG	JC	Dec-17	Green
			Revise section 036 VAP	AZ	JC	Feb-18	Green
			Revise section 039 VHF	IG	JC	Aug-17	Green
			Revise section 042 RCA to incorporate Gram-negative bacteraemia investigation	KB & AG	JC	Aug-17	Green
			Revise section 044 Mortuary	AG	JC	Oct-17	Green
			21 Community IPC Policies to be revised to develop specific policies for GP Practice.	SA	SA	July 2017	Green
3	Implement IPC Education and Training Strategy	Provision of a blended approach to training	Revise induction package	AG	KB	May-17	Green
			Revise IPC e-learning package:WFD to rename sections prior to making available, audit trail in place.	AG & KB	AG	Dec-17	Green
			Deliver CIPCT training 8 half day events across each CCG locality for General Practice, Care Home and Domiciliary Care staff	SA	SA	Mar-18	Amber, some cancelled due to low numbers
			Deliver the Preventing Infection 2 day course held twice a year for all Community Staff	SA	SA	Mar-18	Green
			Deliver IPC Masterclass for Domestic Staff: changed to package for band 2/3 Byland staff as responded to need.	AG	JC	Apr-18	Green
			Develop new resources to support improved HCAI knowledge, skills and practice (eg posters, aide memoirs)	AG & SA	KB	Mar-18	Green
			Confirm support for and once secured, lead delivery of a Safer Care Campaign working collaboratively with Specialist Nurse colleagues (Back to basics)	AG	KB	Mar-18	Green
			Deliver targeted education campaigns e.g. Reduction of catheter-associated UTI, Back to Basics ICED	AG	JC	Mar-18	Green
			Participate in Global Hand Hygiene Awareness Campaign and Antimicrobial Stewardship campaign	AG & SA	JC/JM	May-18 & Nov-17	Green
4.	Monitor compliance with IPC policies	Completion of IPC audit programme and demonstrable	Continue to review approaches for assurance relating to IPC practice including implementation of 2017 High Impact Intervention audits	AG & SA	KB	Mar-18	Green
			Introduce annual hand hygiene audits to lone working community staff	SA	KB	Oct-17	Green

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/18
		improved compliance	Isolation – Audit of single room availability	GM & AG	AG	Oct-17 & Mar-18	Green
			Isolation – Shut the door	GM	AG	Dec 17	Green
			Isolation – Two hour isolation audit	AG & SC	KB	Dec-17	Green
			Isolation – Audit of Equipment	WH	AG	Sep-17	Green
			Isolation – Progress against Competency Assessment Process	CR & IG	AG	Sep-17	Green
			BBV – Audit of Sharps Disposal	AG	KB	Jan-18	Green
			CDI – <i>Saving Lives</i> Audit for every in-patient case	HIPCNS	AG	Apr-18	Green
			CDI – Fortnightly audit of sanitary equipment	WH	AG	Apr-18	Green
			CDI – PII review meetings and action planning	AG	KB	Apr-18	Green
			MRSA – Audit of decolonisation	GM	AG	Feb-18	Green
			MRSA – Audit of patient information	GM	AG	Sep-17	Green
			HH – Monthly audits	Ward/ Dept Mans	AG/SA	Apr-18	Green
			Water safety – Audit of augmented care HH facility use to be reported to Water Safety Group SPEAK to IG /Jim still will sort if not done	Ward/ Dept Mans	AG/IG	Jun-17 & Dec-17	Amber
			Correct use of water filters	WH	AG	Dec 2017	Green
			HH – Audit of posters and point-of-care hand foam	WH	AG	Feb-18	Green
			HH – Quarterly Secret Shopper Audit of patient hand hygiene promotion	GM	AG	Apr-18	Green
			IV – <i>Saving Lives</i> audit for insertion & on-going care	Ward/ Dept Mans	AG	Apr-18	Green
			CVC – <i>Saving Lives</i> audit for insertion & on-going care	Ward/ Dept Mans	AG	Apr-18	Green
			Decontamination – Audit of disinfectant availability	WH	AG	Apr-17	Green

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/18
			Decontamination – Audit of spillage procedure	AG	AG	Apr-18	Green
			Decontamination – Blood glucose testing equipment	WH	AG	Apr-17	Green
			Asepsis – Progress Report of assurance framework implementation:planning in place	IG	AG	09/17	amber
			VAP & Tracheostomy – <i>Saving Lives</i> audit: ITU to take lead, will go onto their annual plan on completion	Ward/ Dept Mans	AG	Apr-18	Amber
			SSI – <i>Saving Lives</i> audit	Ward/ Dept Mans	AG	Apr-18	Green
			Audit Gram-negative bacteraemia cases August-October 2017 to determine proportion that have an indwelling urinary catheter prior to sepsis	SA	JC	Nov-17	Green
			CA-UTI – <i>Saving Lives</i> audit (IPQAT)	Ward/ Dept Mans	AG	Apr-18	Green
			Vertical audit of MSSA/MRSA and CDI RCA (e.g. carried out within target dates)	AG	KB	Apr-18	Amber
			HCAI information – Intranet & Internet	AP&CR	SA&AG	Sep-17	Green
			HCAI information – Audit of discharge documentation (including catheter passport)	SC & AG	JC	Dec-17	Green
			Annual IPC environmental audits of Ripon and Selby MIU Units, the GP OOH Service, Podiatry, Ripon Hospital including Trinity Ward, Outpatients, Physiotherapy, Maternity, Radiology	JC & CG	SA	Apr-18	Green
5	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	Submission of mandatory reports to Public Health England via DCS – MRSA & MSSA bacteraemia; <i>Clostridium difficile</i> infection; glycopeptide-resistant enterococcal bacteraemia; bacteraemia Gram-negative;	AG	JC	Apr-17	Green
			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. (Hemiarthoplasty July-September 2017)	AG	JC	Oct-17	
			Establish a surveillance system to monitor central IV line-related infections central IV line: documented version in place	AZ	AG	Sep-17	Green

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/18
		reduction of hospital attributed HCAI	Continue Alert Organism/Condition surveillance (Hospital-acquired MRSA; <i>Clostridium difficile</i> infection and colonisation; MRGNB; norovirus; MSSA in SCBU; Pseudomonas in ITU, SCBU & Haematology Ward; TPN-related inf; CPE; Urinary catheter prevalence)	AG/CR	AG	Apr-18	Green
			Interrogate 2016/17 Gram-negative bacteraemia case data to steer 2017/18 action plan	JFE/AZ	JC	07/17	Green
6	Further improve communication about HCAI with patients and carers	Increased engagement about HCAI with patients and carers	Review electronic IPC resources on Intranet and HDFT web site	CR & AP	JF/SA	Sept-17	Green - community
			Seek patient feedback re MRSA screening information via audit	GM	AG	Sept-17	Green
			Seek patient feedback /experience of patients with <i>Clostridium difficile</i> (hospital and community)	AG & SA	KB	Apr-18	Green - community
7	Improve cleanliness of equipment and the environment within inpatient settings	Reduction in HDFT-acquired CDI cases	Implement Ward Hygienist action plan and continually review service	AG	KB	Jul/17	Green
			Support implementation of Ward PMDC and HPV/UVC programme	AG	JC	Mar-18	Green
8	Contribute to reduction of HCAI across community settings	Achievement of DH objectives for MRSA Bacteraemia and <i>Clostridium difficile</i> infection for the NYY CCGs	Support PIR process for all NY cases of MRSA bacteraemia. Contribute to RCA review meetings for cases of CDI where indicated. Provide monthly reports for CCGs summarising RCA findings and 6 monthly trend reports.	SA	KB	Apr-18	Green
9	Improve HCAI management within NYY Care Homes	Reduction in cases with MRSA/ <i>Clostridium difficile</i> infection/norovirus outbreaks	Provide service as per service description Use surveillance to identify and prioritise homes requiring additional support Provide IPC education and support for homes requiring additional support. Produce regular newsletters Support Care Home Forums across the CCG's Support Care Homes with outbreaks	SA	KB	Apr-18	Green

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/18
10	Evidence of compliance with IPC Policies	Compliance assurance by implementation of an audit programme for HDFT Community Services	IPC Audit programme for HDFT community bases providing an annual environmental audit for: <ul style="list-style-type: none"> - MIU's at Selby and Ripon - Podiatry across North Yorkshire - Dental across North Yorkshire - Ripon Hospital – Trinity, OPD, Physiotherapy, Radiology, Maternity 	SA	KB	Mar-18	Green
11	Continued development of Community IPC website. Maximise Marketing of resources and increase marketing projects	Increased number of hits to the website and achievement of cost improvement target (£73.5K)	Continue to develop and improve the website raising awareness nationally of IPC resources available to purchase and download. Email newsletters to care homes and GP Practice on alternative months.	SA	KB	Apr-18	Green
			Active marketing of IPC resources Regular communication messages and use of social media	AP	SA	Apr-18	Green
			Attend as an exhibitor at the IPS Conference to launch the new Dental Workbook and other resources	SA/GJ/ AP	SA	Sep-17	N/A not attended
			Optimise training/consultancy opportunities including CQC style inspections for Care Homes and GP Practices	SA	SA	Apr-18	Green
			Develop the 10 th edition Care Home Workbook and other new educational resources	SA/AP	SA	Apr-18	Amber
			Produce a poster for the IPS conference on the Dental Workbook	GJ	KB	Sep-17	N/A
			Consider contracts with external providers	SA/KB	KB	Apr-18	Amber
			Achieve income generation target of £75k	SA	KB	Apr-18	Amber
12	Introduce electronic recording of all patient	Use of SystmOne by CIPCNs	Introduce System One for CIPCT	SA	KB	Aug-17	Green

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/18
	interactions						
13	Reduction of Gram-negative bacteraemia cases in the community	Achievement of reduction target	Support campaign to improve diagnosis and management of UTIs in General Practice and Care Homes	SA	JC	Mar-18	Green

Infection prevention and control plan 2017/2018

- Introduce a MasterClass for HCAs, adapted from the highly successful MasterClass for Nurses programme
- Verbal update for doctors including consultants via the Directorates
- Work with the CCG to reduce *E. coli* bacteraemia, targeting urinary sepsis and infections in residential care first
- Introduce same-day laboratory screening for respiratory viruses
- Introduce point of care respiratory virus testing in A&E and the new Clinical Assessment Unit
- Support the T&O team in the successful implementation of the QIST project
- Review the screening strategy for key target organisms including MRSA and multiply-resistant Gram-negatives
- Review all current infection control policies and revise where necessary

Date of Meeting:	25 July 2018	Agenda item:	11.0								
Report to:	Board of Directors										
Title:	Report from the Medical Director										
Sponsoring Director:	Dr David Scullion, Medical Director										
Author(s):	Dr David Scullion, Medical Director										
Report Purpose:	<table border="1"> <tr> <td>Decision</td> <td></td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<ul style="list-style-type: none"> • Mortality update: The crude death rate increased to 1.12% in June (0.86% last month). This is below the average for the last 12 months (1.16%), but above the rate in June last year (0.79%). Trust HSMR decreased again this month and is now at 104.8 for the rolling 12 months ending March 2018 (105.5 last month). Still no update of the SHMI this month. Case note review into Trauma and Orthopaedic deaths is ongoing. • Gosport Report: The Trust has been asked to confirm to NHSI that infusion pumps of this type are no longer in use in the Trust. The pharmacy department has recently participated in a WY and H audit of opiate use within the Trust. No outlying practice has been identified. • Getting it Right First Time (GIRFT): will be expanded and is now launching a Breast Surgery work stream. • National Cancer Plan for England and the Early Cancer Diagnosis Project, Health Education England is inviting bids for funding for additional clinical endoscopists and reporting radiographers. 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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 identified.										
Resource:	None.										
Impact Assessment:	None.										
Conflicts of Interest:	None identified.										
Reference	None										

documents:	
Assurance:	Not applicable, this report is reserved to the Board of Directors.
Action Required by the Board of Directors:	
<ul style="list-style-type: none"> It is recommended that the Board receives and notes the report. 	

1. Mortality update:

The crude death rate increased to 1.12% in June (0.86% last month). This is below the average for the last 12 months (1.16%), but above the rate in June last year (0.79%).

No alerts generated in **HSMR (April 2017-March 2018)** and **CUSUM (March 2018)** for the periods included.

Trust HSMR decreased again this month and is now at 104.8 for the rolling 12 months ending March 2018 (105.5 last month). This remains within expected levels. At specialty level, two specialties have a higher than expected standardised mortality rate (3 last month) – Geriatric Medicine and Trauma & Orthopaedics. Respiratory medicine is no longer flagging as higher than expected – it is just within the top end of the expected range this month.

There is still no update of the SHMI this month on HED due to a delay in them getting the data from NHS Digital.

Board will be aware of the ongoing case note review into Trauma and Orthopaedic deaths, flagged as an earlier HSMR outlier. At the time of writing, Dr Rebecca Leigh and Dr Angela Bell have reviewed 21 of the 27 sets of case notes using the SJR methodology. All of the reviews have been uploaded to the national Datix mortality review database.

The main theme so far has been one of good care. Most phases of care are graded as 4/5 (Good care/Excellent care). No cases have been submitted for a second case note review. Almost all patients were very elderly, a number with high frailty scores.

Some examples of learning have emerged:

- Late recognition of final illness with benefit of terminal interventions
- Surgical/anaesthetic interventions undertaken by sub-consultant grade in frail patients
- Poor clerking by junior grade doctors
- Returns to x-ray for further imaging

These are isolated incidents rather than themes, not felt to be impactful on overall outcome. The data presented is preliminary for information. When the final review is complete and submitted I shall be asking Drs Leigh and Bell for a summary of lessons learned for future improvement.

2. Gosport report update:

Board will be aware of the recent media interest in relation to the Gosport Inquiry, and specifically the use of the older Graseby MS16/MS26 syringe drivers within the NHS that was highlighted in the Sunday Times. Devices of this type were felt to be inherently inaccurate due to the rather complex nature in which they were primed. This, combined with potential idiosyncratic approaches to opiate and opioid prescribing, could potentiate the likelihood of adverse clinical incidents.

I have recently been asked (as have all Trusts) to confirm to NHSI that infusion pumps of this type are no longer in use in the Trust (since 2014). A more modern and intuitively programmable device is now standard.

The pharmacy department has recently participated in a WY and H audit of opiate use within the Trust. No outlying practice has been identified. I remain confident that were such practice in existence and highlighted, the response of the Trust would be an appropriate and timely one.

Controls to consider might include, but would not be limited to:

- Working practices on particular ward areas – “the way we do it around here”. Is it within agreed norms?
- Response to patient/ relative concerns – collation of repeated themes
- Response to staff concerns/ whistle-blowers/ Freedom to Speak Up guardians
- Effectively dealing with concerns about a doctor through the Responsible Officer decision making forum and MHPS investigation if indicated
- Medical appraisal; 360 feedback
- Accuracy of death certification/ understanding why there is a mortality outlier trigger (and subsequently checking the quality of care rather than simply attributing to coding)/ learning from deaths - Structured judgement reviews
- Controlled Drug use and scrutiny of high usage areas
- Meaningful audits on the standard of care/mortality reviews
- Aspirations for Medical examiner role

3. GIRFT update:

Following the successful completion of the original quality have commissioned an expansion of the GIRFT programme that will cover an additional 35 clinical improvement pilot in orthopaedic surgery entitled Getting It Right First Time (GIRFT), the Department of Health and NHS Improvement (NHSI) areas over four years from April 2017 to support providers in delivering clinical productivity and efficiency improvements. This programme is aligned closely to the Carter work streams in NHSI and the programme is part of the Operational Productivity Directorate of NHSI.

The ambition of the programme is to identify areas of unwarranted variation in clinical practice and/or divergence from the best evidence. Each work stream will culminate in a report and set of national recommendations aimed at improving quality of care and also reducing expenditure on complications, litigation, procurement and unproven treatment. This work will also support the development of the Model Hospital (<https://improvement.nhs.uk/resources/model-hospital/>), which will provide NHS hospital trusts with a set of numbers to compare all areas of efficiency and productivity alongside their quality indicators and standards. It will allow acute trusts, using a number of indicators and benchmarks, to plot productivity by clinical specialty.

GIRFT are now launching the Breast Surgery work stream. This is being led by Fiona MacNeill, Consultant Breast Surgeon at The Royal Marsden NHS Foundation Trust, and Tracey Irvine, Consultant Oncoplastic Breast Surgeon at the Royal Surrey County Hospital NHS Foundation Trust. Fiona MacNeill is a recent past President of the Association of Breast Surgery, and has been a Specialist Consultant Breast Surgeon since 1996, while Tracey Irvine was Clinical Director of the Breast, Skin and Plastics Unit in Surrey where she had experience of delivering quality breast care in a financially challenging environment. The usual GIRFT methodology will apply.

GIRFT have begun a similar programme in Mental Health Services with 1 of 3 national leads recently appointed.

4. Expansion of clinical endoscopy and reporting radiographer workforce:

As part of the National Cancer Plan for England and the Early Cancer Diagnosis Project, Health Education England is inviting bids for funding for additional clinical endoscopists and reporting radiographers. An additional 200 endoscopists are planned by 2012/13. The expansion of the radiographer workforce is designed in the main to free up radiologist time.

HEE is providing a training support package of £15,000 per NHS endoscopy trainee for the September and December 2018 cohorts. This package can be used to support creating sufficient capacity to release trainees from their duties or to provide training capacity when completing the 200 practical procedures within the trust.

The programme which has been developed by HEE working with the Joint Advisory Committee on Gastrointestinal Endoscopy (JAG) comprises of the following key points and features:

- The programme is suitable for either registered nurses and/or HCPC registered healthcare professionals
- Training will provide competence in either upper gastrointestinal (GI) endoscopy or flexible sigmoidoscopy, so successful individuals will be able to perform safe diagnostic procedures. Which technique candidates are trained in is determined by employers
- HEE pays for all fees including university/JAG course fees and a travel allowance for attendance at university (8 days)
- We also anticipate providing employers with a training grant to facilitate staff release
- Employing organisations will be expected to provide clinical supervision and access to clinical lists to enable trainees to complete the necessary 200 clinical procedures, and provide sufficient release from other responsibilities to support trainees to focus on the programme requirements.

The aim of the radiographer reporting scheme is to increase radiographer reporting *capacity* and support will only be provided where the impact of additional reporting capacity and / or release of radiologist reporting time can be demonstrated.

The relevant departments are currently considering their bid applications.

5. Ombudsman (PHSO) update:

A document has been circulated to all Trusts from the PHSO. They have developed new guidance to give greater clarity on how they reach a recommendation for financial remedy. The guidance is designed to ensure that recommended financial remedies are aligned with the scale of injustice experienced by those affected. Guidance is available through the following link to the PHSO website: <https://www.ombudsman.org.uk/organisations-we-investigate/putting-things-right/financial-remedy>

It is worth noting that the Trust has a relatively low number of complaints referred to the PHSO, and an even lower number upheld. Robust internal investigations of complaints that engage and take into account the views of families and patients remains the best defence against any recommendations by external bodies for financial remedy.

6. ARCP pilot for Medical Training Initiative (MTI) doctors:

The Annual Review of Competence Progression is the current workplace based method of performance assessment for training grade doctors. It is held at least once every 12 months and is designed to ensure satisfactory progression against defined competencies and to identify any workforce needs or deficiencies that might act as a barrier to satisfactory training progression. The process is overseen by HEE through the various Deaneries and Training Schools.

It has been suggested by Head of Schools and Directors of Medical Education, that HEE YandH involves the many MTI doctors within the Yorkshire and Humber region in the ARCP process which we co-ordinate and deliver. In the past, we have invited visiting Registrars to an ARCP or RITA.

MTIs are Trust employees, and as such we would continue to be their Responsible Officer.

This is a welcome initiative. Not only could it assist in recruitment to the grade, but it could enhance and inform the process whereby MTIs progress to national training posts and eventual Consultant appointments.

It could also play an important role in helping to identify and correct training needs at an earlier stage.

7. Consultant appointment update:

Unfortunately the advisory appointment committees for two posts (Respiratory Medicine and Community Paediatrics) had to be stood down as both candidates pursued posts elsewhere. Whilst disappointing, we remain committed to filling both posts and will re-invigorate the process.

Date of Meeting:	25 July 2018	Agenda item:	11.1					
Report to:	Board of Directors							
Title:	Sixth quarterly report on safe working hours for doctors and dentists in training							
Sponsoring Director:	Dr D Scullion, Medical Director							
Author(s):	Dr C Gray, Guardian of Safe Working Hours							
Report Purpose:	<table border="1"> <tr> <td>Decision</td> <td>Discussion/ Consultation</td> <td>Assurance</td> <td>✓</td> <td>Information</td> </tr> </table>			Decision	Discussion/ Consultation	Assurance	✓	Information
Decision	Discussion/ Consultation	Assurance	✓	Information				
Executive Summary:	<p>The Board of Directors is asked to note:</p> <ul style="list-style-type: none"> • The Guardian has no on-going concerns. • The number of Exception Reports is below the national average • There is a continuing national recruitment crisis in trainee doctors but vacancies in this Trust are at 9.1% which is comparatively low. 							
Related Trust Objectives								
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>To ensure clinical and financial sustainability:</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	To ensure clinical and financial sustainability:	
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							
Legal / regulatory:	None identified.							
Resource:	None identified.							
Impact Assessment:	Not applicable.							
Conflicts of Interest:	None identified.							
Reference documents:	None.							
Assurance:								
Action Required by the Board of Directors:								
<p>The Board of Directors is asked to receive and note the content of the report.</p> <p>The Board of Directors is requested to consider the points at the end of the report.</p>								

Board of Directors 25 July 2018

Quarter 1 2018/19: Quarterly report on Safe Working Hours: Doctors and Dentists in Training

Report from: Dr Carl Gray, Guardian of Safe Working Hours

Report Purpose: For Information

Executive summary

This is the sixth quarterly report of the Guardian of Safe Working Hours. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This report covers the period 1 April to 30 June 2018. This report is only two months after the last one; a time-tabling glitch on a previous report has now been caught up.

The report provides the Board with up-dated quarterly evidence to support its assurance that the issues of safety within the Guardian's remit are in a satisfactory state.

The Trust now has all trainee doctors employed on the 2016 Terms and Conditions of Service (TCS) contract.

20 Exception reports have been received from trainees and dealt with (Q4 2017/18: 30). These have mainly concerned reduced educational opportunity and over-runs of working hours ('hours and rest') owing to the busy state of the wards and to individual patient matters. Exception reporting is low in this Trust and in decline regionally overall although highly variable.

There having been no breach of the European Working Time Directive, no fine has yet been levied. National trends in medical post-graduate training continue to be adverse.

There has been one regional meeting for guardians this quarter. There has been no national meeting in 2017/18 but a national meeting for Guardians is planned for 17th September 2018 in Leeds. Two trainee doctors' fora have been held jointly with the Director of Medical Education. These will continue bi-monthly.

The CQC have announced that they will henceforward in inspections interview Guardians of Safe Working and representative trainee doctors concerning exception reports.

National developments include a review of the 2016 Contract by NHS Employers and BMA to be completed by August 2019 and a piece of work on improving exception reporting.

This is the key quality assurance statement for the Board:

'The Board is advised that overall working hours across the organisation are satisfactory and that there are presently no unaddressed specific concerns in departments or directorates.'

1 Introduction

This is the sixth quarterly report of the Guardian of Safe Working Hours which presents the Trust's statistics in brief form: more detailed data is held in the DRS computer system and available on request.

Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. The quarterly report is a contractual duty upon the employer under the 2016 TCS.

The report provides the Board with up-dated quarterly evidence to support its assurance that the issues of safety within the Guardian's remit are in a satisfactory state.

The Trust now has all its trainee doctors employed on the new 2016 TCS which started in December 2016.

Owing to the Trust taking on a new lead employer role for the GP training scheme, the Guardian has been requested to take on the guardian role for ~30 GP specialty trainees on placement with GP surgeries in the Harrogate District. This should not be onerous as these trainees work nine to five and are 'low maintenance.'

2 High level data

In July 2018:

The position is unchanged since May 2018:

Number of doctors / dentists in training (total established Deanery posts)	121 [last quarter: 121]
Number of doctors / dentists posts on 2016 TCS (total)	121 [last quarter: 121]
Number of doctors / dentists in training actually in post	110 [last quarter: 110]
Number of doctors/dentists in Trust posts (additional to Deanery posts)	14 [last quarter: 14]
Number of doctors/dentists in Trust posts actually in post	13 [last quarter 13]
'Gaps' in deanery posts	9.1%
'Gaps' in deanery and Trust posts combined	8.9%
Amount of time available in job plan for Guardian to do the role	1.5 PAs per week
Admin support provided to the Guardian (if any)	none [assistance from HR Department]
Amount of job-planned time for educational supervisors	0.5 PAs per trainee

3 Exception reports

Exception reports are individual notifications by trainee doctors who have had a problem occasion causing them to vary their working hours from the contracted rota by more than ½ hour. Exception reports have a time-limited process for response by the Trust. At any one time there may be a few reports awaiting attention by individual clinical supervisors.

This is a full quarter covering the period 1 April – 30 June 2018.

Exception reports by department: hours/rest & educational				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Surgery	0	15	15	0
General Medicine	0	5	5	0
Total	0	20	20	0

The exception reports were received from 13 FY1 doctors and the rest from specialist registrar grades. The majority of exceptions reported concern defective educational experience, usually missed opportunities to attend clinic, ward round or theatre sessions. Others are of over-working hours owing to exceptional circumstances ['hours and rest']. Some exception reports mention both categories of 'hours and rest' and 'education'. Education exceptions are seen by the Director of Medical Education.

Exception reporting has a potential procedural barrier. Doctors new to the Trust must activate their password on the DRS system within seven days. If they do not do so they are locked out and must get a new password. This may account for some delay in reporting exceptions; some doctors tend to batch them.

If a doctor has overworked their contracted hours on an occasion, then they are entitled under the TCS to over-time pay or time off in lieu. If the over-work is caused by rota gaps, then time off is not appropriate if it will compound the shortage situation. The doctor is entitled to overtime pay even if their overtime commitment followed from their own inefficiency or misjudgment. Clinical supervisors are expected to guide their trainees in efficient working, prioritizing clinical activities and making timely hand-overs to over-night teams. The Trust will incur a small cost each month in some hours' over-time pay; but this is offset somewhat by vacant posts owing to rota gaps. But overall, the Trust is heavily over-spent on medical locum costs for consultants and trainees.

The job of filling posts, balancing rotas and workloads properly belongs to clinical directorates with professional support from the HR function. Individual trainees' employment experiences are managed by their individual clinical supervisor - a clinical consultant usually in the same or a related specialty. The Guardian has no actual managerial power over individuals in directorates.

Of course, ideal conditions of employment for trainee doctors are one obligation amongst many in the Trust, particularly in periods of winter pressures.

4 Work schedule reviews and interventions

4a Work schedule review

A work schedule review would be undertaken to investigate any case of systematic or repeated over-working of contracted hours where the planned schedule itself is questioned. No work schedule review has been necessary to date.

4b Interventions

No intervention has been necessary this quarter.

The Medical Workforce department has had an issue concerning alleged non-compliance of rotas with the European Working Time Directive. This appears to be a misunderstanding in process of resolution. No individual issues have arisen for the Guardian.

5 Vacancies

The vacancies are unchanged from May 2018 as reported last quarter. There were 11 [Q4: 11] vacancies in July 2018 [9.1% of 121 deanery established posts overall]. This is in the end days of the current six-monthly rotation of trainees. Two posts are agreed to be vacant with the departments concerned for various reasons.

In February and August each year there are planned cohort changes; at other times of year there are always a few doctors coming and going for personal reasons. At any one time, there are gaps owing to failure of recruitment and vacant posts are at different stages of re-advertisement and recruitment. Departments may decide not to fill posts for various reasons: for example, the part-year Chemical Pathology post is currently unfilled by choice of the department.

Medical Workforce and Recruitment are just now finalising the new intake for 1st August 2018. Gaps seem to be fewer this time with an improving trend over time. The successful filling of rota gaps is of course a measure of the diligence and ingenuity of the Medical Workforce and Recruitment team.

Of course, any rota gaps will add to the strain on the trainees in post and add to the Trust's workforce costs by necessitating locum and other temporary employees and working down of senior grades of staff.

The percentage of vacancies is worse in other Trusts: we are doing relatively well.

The Guardian has access to the HR database of trainee doctors which is up-dated monthly.

6 Fines

The Guardian has the contractual power to penalize departments/directorates for failure to ensure safe working hours and particularly repeated breaches of the Working Time Directive. This section should list all fines levied during the previous quarter, and the departments against which they have been levied. Additionally, the report should indicate the total amount of money levied in fines to date, the total amount disbursed and the balance in the Guardian of Safe Working Hours' account. A list of items against which the fines have been disbursed should be attached as an appendix.

No fine has been necessary to date. There have been no identified breaches of the Working Time Directive. Fines have been levied in other trusts in the thousands of pounds.

Working time rules may of course change after BREXIT.

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£0	£0	£0	£0

7 Regional Meeting

There has been one regional meeting for Guardians this quarter, on 2nd July 2018 at Leeds.

There is news of two national developments.

Firstly, the original 'agreement' – it was of course never agreed but imposed - in 2016 for the new trainee doctors' contract included a commitment to a joint review in 2018/19. BMA is these days cooperating closely with this in the interests of improving the contract for its members. This is now being taken forward jointly by NHS Employers and BMA for the staff side. The review of the working of the contract will examine five main themes which are: less than full-time working; workforce issues; pay structure; safety and well-being and the training interface. The review will run from July 2018 to August 2019 starting with data collection in the second half of 2018. Re-negotiation will take place with BMA in January to May 2019. The review ought to be completed with any agreed changes to the contract ready for August 2019.

Secondly, NHS Employers and NHS Improvement have together realized that exception reporting as currently implemented is a poor instrument for gaining feedback on trainees' working lives. They have therefore started a 'piece of work' to improve exception reporting. This intends to look at the template of data collected in exceptions and to bring 'standardisation' across the nation. NHSE and NHSI together intend to consult BMA, Academy of Royal Colleges, CQC, General Medical Council, Health Education England, and numerous trainees and NHS trusts. This work is to be completed in 2018.

The regional meeting heard a presentation from Ian Wilson, a regional representative of the General Medical Council, a former police officer. He explained that the GMC regards the case of Dr Bawa-Gaba – see previous reports – as an utter disaster. This doctor was found to have contributed to the death of a patient in Leicester in highly pressured circumstances. She was convicted of manslaughter and struck off the medical register. The criminal convictions have been to the Court of Appeal and pronounced 'safe'. The striking off is subject to appeal processes currently.

GMC is aware that the case – notwithstanding the tragic death of a child – has caused immense anger in the medical profession and loss of confidence in their regulator. The profession feels that insufficient account was given to the circumstances of the case and the acknowledged systemic failing of the Trust and its working environment. There has been misreporting and misunderstanding of the case. The consequences include doctors becoming reluctant to record reflections in training and appraisal documents. There is a strong sense that the disaster could have befallen any trainee working in pressured specialties. GMC official advice has been feeble: trainees in difficult circumstances must not walk away but must report these upwards in management and to the Guardian. Thereby they 'immunise' themselves against criticism but this does not necessarily relieve the difficulties. The Law Commission is reconsidering how the criminal law addresses medical negligence.

Reportedly, recruitment to GP training has picked up somewhat.

Immigration controls on doctors wanting to enter and work in the UK are being relaxed.

There will be a national meeting for guardians of safe working hours to be held on 17th September 2018. This time the meeting is conveniently to be held in Leeds.

8 Trainees' Forum

Recent fora have been well attended. In informal discussion with the young doctors, it is striking how few of our current trainees intend to follow a linear training programme in the 'normal' way. There appears to be a worsening trend in trainees avoiding deanery training programmes. Only about 50 per cent of trainees proceed directly from FY School to higher training in primary care or hospital specialties. Many good trainees are choosing the non-deanery route and intend to spend a few years in short-term trust posts variously termed 'FY3' and 'Trust Doctor' or going abroad.

Anecdotally, the young doctors who go abroad or leave medicine will return after an interval.

The medical [and of course other health care professional] workforce issues previously discussed with early retirement of seniors and reluctance to proceed through training in the juniors continue to be the defining issue for the NHS in the next decade.

9 Disclosure

These quarterly Guardian reports are submitted to Health Education England at their request and by standing consent of the Trust Board of Directors. A regional summary is assembled and discussed at the regional meeting each time. Guardians assume that their quarterly reports to their boards of directors are open to the public domain.

Health Education England will receive periodical download of the entire database of exception reports for the purpose of research by the mining of big data. The Board has agreed to this.

10 Confidentiality

Given that Guardians' reports may be in the public domain, the identities of specialties, doctors and supervisors are concealed in the Guardian's quarterly report. Full data is available to the Board of Directors in private session on request.

11 CQC

There has been no enquiry from CQC to date.

Future CQC inspections will include inspectors in addition to usual practice interviewing the Guardian of Safe Working Hours and representative trainee doctors about exception reports. Quarterly reports [such as this document] will be submitted for inspection.

12 Issues arising

- a. The Trust continues in comparatively good standing. We have had a below-average rate of exception reporting and a particularly low number last quarter.
- b. There is an on-going problem of sporadic over-work and reduced educational opportunity for trainee doctors owing to colleagues off sick and rota gaps.
- c. Reluctance in trainees to report exceptions exists regionally and nationally.
- d. Exception reports are being received and processed.
- e. There are gaps in rotas owing to failed recruitment. This a worsening issue throughout medical specialties especially in the North of England, but this Trust is doing relatively well.
- f. The Guardian is expecting to meet CQC inspectors in due course.

- g. NHS Employers and BMA are reviewing the 2016 contract in fulfilment of the original promise to do so. This review and any contractual changes are expected to be completed for August 2019.
- h. NHS Employers and NHSI are working on improving exception reporting in 2018.

13 Actions taken to resolve issues

- a. No fine has been necessary this quarter.
- b. No intervention has been necessary this quarter.
- c. At the date of reporting, the Board of Directors is assured from the evidence available that:
 - i. The exception reporting system is operational for all trainees; they are now all on the 2016 TCS.
 - ii. No systematic problem of unsafe working hours is known to exist currently.
 - iii. The Guardian can only intervene on notified problems.
 - iv. The Guardian will continue to attend regional and national meetings.

14 Questions for consideration by the Board of Directors

- a. The Board is asked to receive the quarterly report and to consider the assurances provided by the Guardian.
- b. There are presently no issues outlined in the report which are not being (or cannot be) tackled.
- c. The Guardian makes no request for escalation, internally, externally or both, which might be recommended in order to ensure that safe working hours would not be compromised in the future.
- d. Issues of medical [and indeed all healthcare professional] workforce planning are an urgent strategic challenge to the Trust and to the entire NHS. The Trust always has vacancies gaps in trainee doctor posts; these currently run at 9.1 per cent.
- e. Safe working hours, trainees' exception reports and rota gaps now are added to the regular data requests by CQC in their inspection process.
- f. HEE has access to our exception reporting data.

Dr Carl Gray

Guardian of Safe Working Hours
17th July 2018

Date of Meeting:	25 July 2018	Agenda item:	11.2								
Report to:	Board of Directors										
Title:	Learning from deaths report Q1 2018/19										
Sponsoring Director:	Dr David Scullion, Medical Director										
Author(s):	Dr Sylvia Wood, Deputy Director of Governance										
Report Purpose:	<table border="1"> <tr> <td>Decision</td> <td></td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	Board to note quarterly report of learning from deaths process.										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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.										
Action Required by the Board of Directors:											
It is recommended that the Board <ul style="list-style-type: none"> Notes items included within the report; 											

Learning from deaths report: Q1 2018/19

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). The Trust has a number of clinicians trained to undertake the structured judgement review. 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 yet proving useful to prepare data for this report. We are communicating with Datix about this. We are also close to testing an in-house platform that will enable us to implement a screening process for all in hospital deaths, to prioritise early review of deaths that would or might benefit from a SJR.

The date of death is the date that we aim to use for the data analysis rather than the date that the SJR was undertaken. However this is currently difficult in that there is not a date of death field on Datix – only the quarter in which the death occurred – without the relevant year. This introduces the potential for error when some historic cases are being reviewed at the same time as current cases.

Some of the SJRs undertaken during Q1 relate to deaths that occurred during 2017/18 for various reasons including:

- Trauma & Orthopaedics has been flagged as a negative outlier for HSMR for the first time, in relation to the period Feb-17 to Jan-18. The patients who died during this period have been identified and the work to review and undertake a SJR has been progressed with 21 out of 27 completed.
- Patients with learning disabilities who were referred to the LeDeR programme during 2017/18. All cases of a patient with learning disabilities dying in hospital are automatically referred to the national LeDeR programme. This is the national multi-agency programme for review of death in patients with learning disabilities commissioned by NHS England.

All case note reviews undertaken during 2018/19 Q1 have been included in this report.

Results

Numbers of inpatient deaths and case note reviews undertaken during Q1 2018/19

	2017/18				2018/19
	Q1	Q2	Q3	Q4	Q1
No of inpatient deaths	145	140	167	205	142
SJR previously reported	3	8	14	6	N/a
SJR undertaken during Q1	5	4	9	7	8
Total SJRs undertaken relating to deaths in the period	8	12	23	13	8

Numbers of case note reviews undertaken in total

	2014/15	2015/16	2016/17	2017/18	2018/19	Total
					Q1	
SJR previously reported	4	27	40	31	N/a	102
SJR undertaken during Q1	0	0	0	25	8	33
Total number of SJRs undertaken relating to deaths in the period	4	27	40	56	8	135

Assessment of care – case note reviews undertaken in Q1 2018/19

	Good or excellent care (score 4-5)	Average care (score 3)	Poor care (score 1-2)	N/a	Total
Admission and initial management	26	3	4	0	33
On-going care	28	2	0	3	33
Care during procedure	19	0	0	14	33
Peri-operative care	15	1	0	17	33
End of life care	30	3	0	0	33
Overall assessment of care received	32	1	0	0	33
Overall assessment of patient record	32	1	0	0	33

Problems with care – case note reviews undertaken in Q1 2018/19

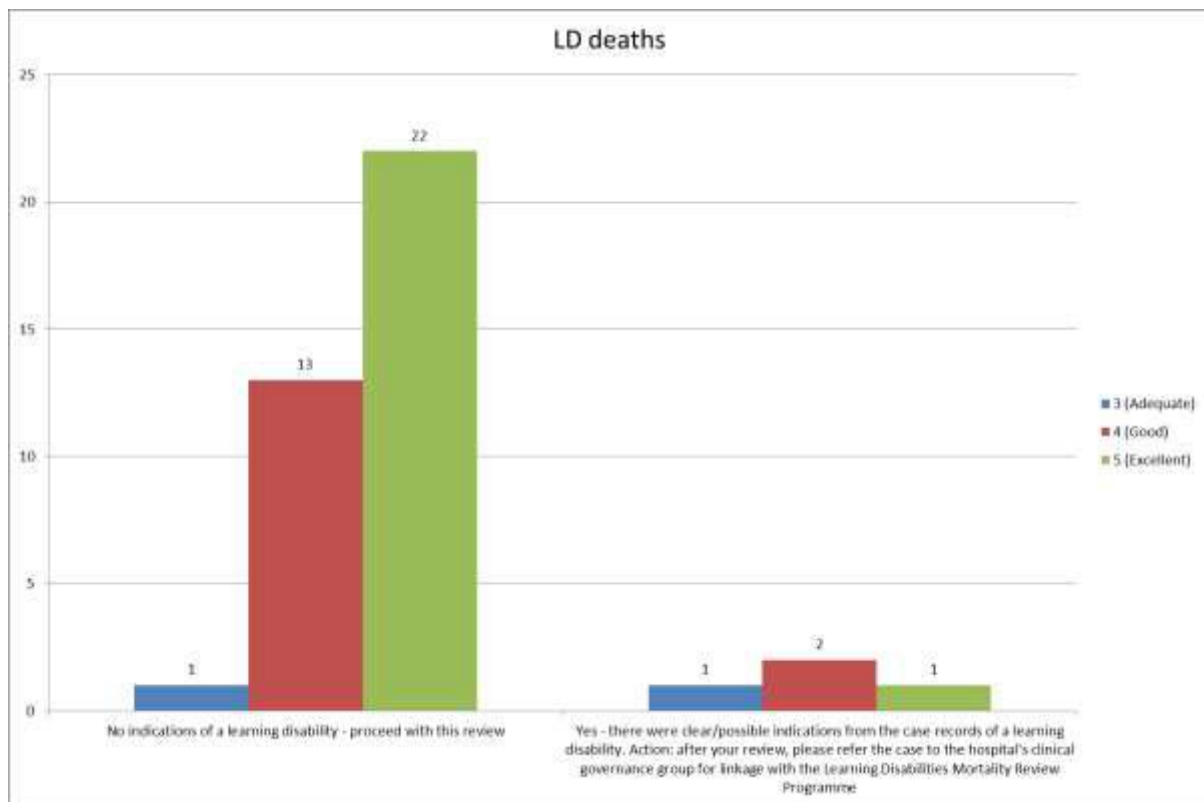
The SJR proforma has a section that enables the identification of problems in care by various categories described in the table below. Of the 33 case note reviews undertaken in Q1 2018/19:

- 28 cases with no problems in care
- 5 cases with a total of 6 problems in care documented in various categories. Of these:
 - 5 were deemed to have resulted in no harm. These largely related to admission and initial assessment e.g. no swallowing assessment in ED prior to oral intake; not admitted directly to stroke unit from ED; Not clerked on return from Leeds; failure to recognise frailty and start anticipatory planning as a result - would not have changed outcome.
 - 1 problem related to operation /invasive procedure and resulted in harm. This death was immediately referred to Coroner by the Medical Director and an internal Trust full comprehensive RCA investigation is under way. The death was reported to June Board of Directors (private section). The SI report to return to Trust Board when complete.

Deaths of patients with learning disabilities compared to overall assessment care rating

There were 3 deaths of patients with learning disabilities that underwent a SJR during Q1. There were no problems in care identified and the overall assessment score was 5 (excellent) in one case and 4 (good) in two cases.

The graph below shows the overall assessment of care for patients with / without learning disabilities (no=4) and without learning disabilities (no=36) from all HDFT SJRs recorded on Datix (n=40).



Orthopaedic HSMR outlier review

Regarding the 27 deaths included in the orthopaedic HSMR for the period Feb-17 to Jan-18, 19 case reviews have been completed and included in this Q1 report. The main theme so far is of good or excellent care with most scoring 4 or 5 for overall care. These reviews have been completed by the orthogeriatricians, who are confident about the findings but have asked some other physicians to review some of the remaining cases to reduce any concerns of bias.

Specific learning points identified

- Patients assessed in ED as having stroke should not be given oral intake prior to swallow assessment.
- Patients with stroke should be admitted to the stroke unit, not other medical wards.
- Patient transferred back from other hospitals should have a timely medical assessment.
- Orthogeriatric input should be considered at pre-assessment clinic to manage frailty and start advanced care planning.
- Death certificate needs to be complete and include recent hip fracture and surgery.
- Ensure correct Coronial procedures are followed.
- Difficulty in seeking advice using online Neurosurgical referral system when holistic and contextual decision is indicated. A patient had 3 CT brain scans on 3 consecutive days when alternative reasons for deterioration were evident: high sodium/ AKI/ Parkinson's medication changes/ delirium. Prognostic conversations took place after 3rd scan.

- Need to minimise delays related to PEG insertion for patients who are otherwise nil by mouth. There was a period of 9 days when one patient had no nutrition. Otherwise care was excellent and the patient's family was involved and kept updated.

Reflection

In general the reviews were of good quality with numerous detailed descriptions of good practice. In a smaller proportion of cases, examples of where practice could be improved were documented. There was only one case where a problem in care was associated with harm. This death is subject to a serious incident investigation.

Regarding the 27 deaths included in the orthopaedic HSMR for the period Feb-17 to Jan-18, the main theme so far is of good or excellent care with most scoring 4 or 5 for overall care.

Regarding deaths of patients with learning disabilities, there were 3 SJRs undertaken during Q1. There were no problems in care identified and the overall assessment score was 5 (excellent in one case and 4 (good) in two cases).

Learning

1. Local dissemination is through feedback to teams and across the organisation where appropriate. This will be led through the Improving Patient Safety Steering Group (IPSSG). ChatterMatters, the patient safety newsletter will be used to share general learning from the learning from deaths process across the organisation.
2. At national level the new web based methodology for documentation of SJR using Datix, will enable identification of themes and wider learning.

Board Committee report to the Board of Directors

Committee Name:	Quality Committee (QC)
Committee Chair:	LA Webster
Date of last meeting:	04/07/2018
Date of Board meeting for which this report is prepared	July 2018

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

Hot Spots: Jill Foster advised the Committee of indications, within one of the Directorates, that there has been a breach of professional standards in relation to Information Governance. Immediate action is to remind all staff of the protocols for accessing an individual's health data.

Board Request for QC to seek assurance:

- QC asked to consider if the work-plan provides adequate assurance on quality care for children's services. Concluded that whilst there is some good assurance, this could be improved. To address this, QC will receive additional assurance via the data being worked up for inclusion in the new Quality Dashboard. *Item to remain an action until this data has been verified.*
- Pressure Ulcers: Annual Pressure Ulcers Report received.
 - Noted successful achievement in Community Care of both the target for reduction and the education programme.
 - Noted remaining challenge for achieving target in Acute Care.
 - QC assured that there are a good number of initiatives being monitored within both settings to continue towards reducing the risk of avoidable pressure ulcers.
- Falls: Annual Falls Report received.
 - Noted the range of initiatives to prevent falls implemented, however results from the most recent audit showed number of falls remaining static since previous audit.
 - Noted risk of reduction of services in community until new methodologies are worked up.
 - QC requested update from results of next audit due October 2018.

Reports Received:

QC received assurance on the following reports:

- Quality Dashboard: The new version of the Quality Dashboard has been well accepted by all areas and it has been agreed that this will now be the version received at QC.
- LTUC Directorate - Annual Reports from Directorate Governance Groups
- Clinical Audit Plan – Verbal report
- External Reports – Summary of progress against action plans
- National diabetes in-patient audit (NADIA) 2017
- NDA Pump audit 2016-17
- Report on the Short Life Working Group (SLWG) on reducing medication-related harm

Other Items

- QC requested copy of Gosport Memorial Hospital Report be circulated to all Board and QC members.
- Changes to meeting calendar agreed:
 - Meeting dates in August & November cancelled
 - Meeting dates in January and February to be merged
 - October will be a reduced agenda to facilitate a workshop opportunity for QC to consider current and future work-plan
- The meeting was observed by Alan Elliot as part of the external audit process.

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

Note 'Hot Spot' item

Matters for decision

None

Action Required by Board of Directors:

1. Note implementation of new Quality Dashboard
2. Note Meeting date changes