Harrogate and District NHS Foundation Trust

The meeting of the Board of Directors held in public will take place at 9.00am on Wednesday 25 September 2019 in the Boardroom, Trust HQ, Harrogate District Hospital, HG2 7SX

AGENDA			
Item No.	**Item**	**Lead**	**Paper No.**
9.00am – 9.20am			
Patient Story – patient will be supported by Vicky Draper, Community Stroke Team Leader			
9.20am – 11.00am			
1.0	**Welcome and Apologies for Absence:** Mrs Foster, Chief Nurse Dr Lyth, Clinical Director, Children's and Countywide Community Care Directorate	Mrs A Schofield, Chairman	-
2.0	**Declarations of Interest and Register of Interests** *To declare any interests relevant to the agenda and to receive any changes to the Register of Interests*	Mrs A Schofield, Chairman	2.0
3.0	**Minutes of the Board of Directors meeting held on 31 July 2019** *To review and approve the Minutes of the meetings*	Mrs A Schofield, Chairman	3.0
4.0	**Review Action Log and Matters Arising** *To provide updates on progress of actions* **4.1 Report on Respect programme and End of Life Care – TO FOLLOW** *For review and comment*	*Mrs A Schofield, Chairman* *Dr D Scullion, Medical Director*	4.0 4.1
Overview by the Chairman		Mrs A Schofield, Chairman	-
5.0	**Report by the Chief Executive** **5.1 Integrated Board Report** **5.2 Finance Report** **5.3 Operational Performance Report** **5.4 Medical Director Report** **5.5 Chief Nurse Report**	Mr S Russell, Chief Executive Mr J Coulter, Director of Finance Mr R Harrison, Chief Operating Officer Dr D Scullion, Medical Director Mrs A Mayfield, Deputy Chief Nurse	5.0 5.1 5.2 5.3 Verbal Verbal

You matter most

	5.6 Workforce and Organisational Development Report	Ms A Wilkinson, Director of Workforce and Organisational Development	5.6
	To deliver high quality health care		
6.0	**6.0 Summary from Quality Committee meeting of 4 September 2019** *To be considered and discussed*	Ms L Robson, Chairman	6.0
	6.1 Learning from Deaths Quarterly update *To be considered and discussed*	Dr D Scullion, Medical Director	6.1
	6.2 Freedom to Speak Up Guardian Update *To be considered and discussed*	Dr S Wood, Freedom to Speak Up Guardian	6.2
	6.3 Guardian of Safe Working Hours Quarterly report *To be considered and discussed*	Dr D Scullion, Medical Director	6.3
	6.4 Annual Medical Revalidation and Appraisal Statement of Compliance *For consideration and approval*	Dr D Scullion, Medical Director	6.4
	6.5 Digital Strategy 2019 – 2024 *For consideration and approval*	Mr R Harrison, Chief Operating Officer	6.5
11.00am – 11.15am			
Break			
11.15am – 12.30pm			
	To work with partners to deliver integrated care		
7.0	**7.0 West Yorkshire and Harrogate Partnership**	Mr Steve Russell, Chief Executive	Verbal
	To ensure clinical and financial sustainability		
8.0	**8.0 Summary from Resources Committee meetings of 27 August, and 23 September (**to follow**)** *To be considered and discussed*	Mrs M Taylor, Chairman of Resources Committee	8.0
	Governance		
9.0	**9.0 Review of Third Party Schedule** *For review and approval*	Mrs A Schofield, Chairman	9.0
	9.1 Harrogate Integrated Facilities (HIF) - Board Composition *To consider for approval*	Mr R Harrison, Chief Operating Officer	9.1
	9.2 Review of Standing Orders *For review and approval*	Mrs A Schofield, Chairman	9.2
	9.3 Summary from Audit Committee meeting of 11 September 2019 *To be considered and discussed*	Mr C Thompson, Chairman of Audit Committee	9.3

	9.4 Minutes of the Council of Governors' meeting of 1 May 2019 *To receive and note* **9.5 Amendment to the Trust Constitution – Change of title from Deputy Chairman of Governors to Lead Governor** *To receive and approve*	Mrs A Schofield, Chairman Mrs A Schofield, Chairman	9.4 9.5
10.0	**Any other relevant business** *By permission of the Chairman*	Mrs A Schofield, Chairman	-
	Board Evaluation	Mrs A Schofield, Chairman	-
Confidential Motion – the Chairman to move: *Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.*			

Harrogate and District NHS Foundation Trust

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 September 2019.

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

Harrogate and District NHS Foundation Trust

Dr Natalie Lyth	Clinical Director CCCC	1. Member of North Yorkshire Local Safeguarding Children's Board and sub-committees. 2. Chair of the Safeguarding Practice Review Group. 3. Chair of the North Yorkshire and York Looked After Children Health Professionals Network. 4. Member of the North Yorkshire and York Safeguarding Health Professionals Network. 5. Member of the national network of Designated Health Professionals. 6. Member of the Royal College of Paediatrics and Child Health Certificate of Eligibility of Specialist Registration (CESR) Committee and assessor of applications for CESR.
Ms Laura Robson	Non-Executive Director	1. Familial relationship with Alzheimer's Society
Mr Steve Russell	Chief Executive	None
Mrs Angela Schofield	Chairman	1. Member of WYAAT Committee in Common 2. Volunteer with Supporting Older People (charity). 3. Chair of NHS Northern Region Talent Board
Dr David Scullion	Medical Director	1. Member of the Yorkshire Radiology Group 2. Familial linkage with Freedom to Speak Up Guardian
Mr Richard Stiff	Non-Executive Director	1. Director of (and 50% owner) Richard Stiff Consulting Limited 2. Director of NCER CIC (Chair of the Board from April 2019) 3. Director and Trustee of TCV (The Conservation Volunteers) 4. Vice Chair of the Corporation of Selby College 5. Member of the Association of Directors of Children's Services 6. Member of Society of Local Authority Chief Executives 7. Local Government Information Unit Associate 8. Local Government Information Unit (Scotland) Associate 9. Fellow of the Royal Society of Arts
Mrs Maureen Taylor	Non-Executive Director	None
Mr Christopher Thompson	Non-Executive Director	1. Non-Executive Director of Harrogate Healthcare Facilities Management Limited (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust) 2. Director – Neville Holt Opera Limited 3. Deputy Treasurer and Member – Council of the University of York 4. Chair – NHS Audit Yorkshire Consortium 5. Chair – Tissue and Organ Donation Committee HDFT

Harrogate and District NHS Foundation Trust

Mrs Lesley Webster	Non-Executive Director	None
Ms Angela Wilkinson	Director of Workforce and Organisational Development	None

Harrogate and District NHS Foundation Trust

Deputy Directors attending Board meetings as substitutes

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

Harrogate and District NHS Foundation Trust

Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors' meeting held in public on
Wednesday 31 July 2019 at 9.00am in the Boardroom at Harrogate District Hospital

Present:	Ms Sarah Armstrong, Non-Executive Director Mr Jonathan Coulter, Deputy Chief Executive/Finance Director Mr Robert Harrison, Chief Operating Officer Mrs Alison Mayfield, Deputy Chief Nurse Ms Laura Robson, Non-Executive Director Mr Steve Russell, Chief Executive Mrs Angela Schofield, Chairman Dr David Scullion, Medical Director, Mr Richard Stiff, Non-Executive Director Mrs Maureen Taylor, Non-Executive Director Mr Chris Thompson, Non-Executive Director/Vice Chairman Mrs Lesley Webster, Non-Executive Director Ms Angela Wilkinson, Director of Workforce and Organisational Development
In attendance:	Mr Andrew Alldred, Clinical Director, Long Term and Unscheduled Care Mr Andrew Forsyth, Interim Company Secretary Mr Ben Goode, Patient Experience Officer (Patient story only) Dr Claire Hall, Deputy Medical Director Dr Kat Johnson, Clinical Director, Planned and Surgical Care Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services Mrs M (Patient story only)

Patient Story

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

Mrs Schofield welcomed Mrs M, who was supported by Mr Goode from the Patient Experience Team. Mrs M had developed gestational diabetes in her pregnancy. Overall experience of the Trust's maternity services had been positive and the team had been very welcoming. However she wanted to highlight three issues which related to the monitoring of her blood sugar levels, the information she had received regarding being induced and the monitoring of her baby's blood sugar levels.

Mrs Schofield thanked Mrs M for her story and noted that there was lots of learning; she asked Mr Goode what had happened since. Mr Goode advised that the ward manager had instituted an action plan which included improving the gestational diabetes testing regime and the information given to diabetic mothers.

A discussion took place with Mrs M where she confirmed that her concerns had been taken seriously and she had been kept up to date with the actions taken. Questions were raised about patients being allowed to self-test and the availability of appropriate diets. Mrs M said that her ante natal care had been outstanding and commended the support of the specialist diabetes nurses.

Mrs Schofield thanked Mrs M for bringing her story to the Board. She was pleased to have heard that her baby was doing well and she thanked Mr Goode for his support for Mrs M.

Mrs Schofield said that it was important to ensure that all aspects of Mrs M's feedback were addressed appropriately by the team and Dr Johnson agreed to follow this up. It was suggested that a video of Mrs M's story could be made to ensure maximum benefit was derived from her experience. Mrs Schofield said that she would write to Mrs M and Mr Alldred agreed to ensure the compliments about the specialist diabetes nurse were passed to her.

Action:
Mrs Schofield to write to Mrs M.
Mr Alldred to pass compliments to specialist diabetes nurse.

1.0 Welcome and Apologies for Absence

1.1 Mrs Schofield noted there were apologies for absence from Mrs Foster, Chief Nurse and welcomed Mrs Alison Mayfield, Deputy Chief Nurse in her stead.

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

1.3 Mrs Schofield welcomed four Governors, Ms Stewart and Mr Stott, who had been elected recently, and Ms Cressey and Mr Cowans, and two members of the public. In addition she congratulated Mrs Harrison (Deputy Director of Workforce and Organisational Development) on her appointment as Director of Workforce and Organisational Development at Airedale NHS Foundation Trust and welcomed Ms Shirley Silvester, who would take up the Deputy Director role temporarily.

2.0 Declarations of Interest and Board Register of Interests

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

3.0 Minutes of the meetings of the Board of Directors on 24 May 2019, 29 May 2019 and 26 June 2019

The draft Minutes of the meeting held on 24 May 2019 were approved without amendment.

The draft Minutes of the meeting held on 29 May were approved subject to the following amendments:
Patient story – paragraph 5 last sentence:
Insert: 'following the death of their father.'

Minute10 paragraph 10.2, final sentence:
Delete: 'add some details…….reports.'
Insert: 'to indicate where the details of maternity and paediatric deaths were reported, because this was not included in the Learning from Deaths report.'

The draft Minutes of the meeting held on 26 June 2019 were approved without amendment.

APPROVED:
The Board of Directors approved the Minutes of the meetings held on 24 May and 26 June 2019 without amendment and the Minutes of the meeting held on 29 May 2019 as accurate records of the proceedings, subject to the agreed amendments.

4.0 Review of Action Log and Matters Arising

4.1 Action 81: Mr Harrison confirmed the Integrated Board Report (IBR) would be reviewed with a revised version available for the November meeting of the Board.
4.2 Action 135: Board action complete.
4.3 Action 136: This was awaiting full details of the merger.
4.4 Action 137: Closed as a separate action and included under Action 81.
4.5 Action 138: Mr Coulter reported that the Department of Health and Social Care (DHSC) had invited bids against central funds with a deadline of 24 September. Board action complete.
4.6 Action 139: Dr Scullion confirmed that he had discussed this with the Guardian of Safe Working Hours and SAS doctors would be included, although technically his remit only applied to doctors in training. Board action complete.
4.7 Action 142: Board action complete.
4.8 Action143: The Trust has an IT Clinical Safety Officer and he attends the Improving Patient Safety Steering Group. IT issues are reported to the Senior Management Team. Board action complete.
4.9 Action 144: The discussion is programmed for the Board workshop in August.
4.10 Mr Coulter wished the Board to note that the delayed Accounts element of the Annual Report and Accounts 2018-19 (AR&A 2018-19) was submitted to NHSI and the complete AR&A was laid before Parliament on 10 July 2019.
4.11 There were no other matters arising.

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

Chairman's Report

Mrs Schofield noted a number of items:

- The Annual Members Meeting, held on 24 July, had been .Ms Armstrong felt that the tone had been right and complex information had been presented in an accessible and interesting way. Mrs Webster thought that the annual report summary document was very good.
- Five new Governors had been elected to the Trust – Ms Samantha James, Dr Loveena Kunwar, Mr Doug Masterton, Mrs Helen Stewart and Mr Dave Stott – and she extended a warm welcome to them.
- Mrs Schofield noted that the process for appointing two new Non-Executive Directors was underway, with the support of Gatenby Sanderson. The requirement was for the successful candidates to have either financial or transformational skills and the process was targeted on attracting candidates from the north east area of the Trust's footprint and from BAME communities. Longlisting would take place on 4 September, shortlisting on 30 September and final interviews on 14 October, with a view to inviting the Council of Governors' meeting to endorse the selections on 6 November.
- The Pensions Committee had discussed the issues around the lifetime and annual allowances at its meeting on 26 June, which would be reported later in the meeting.
- She noted that the Board workshop on 26 June had included discussion about the People Plan, the Communications and Marketing policy, the financial plan and North Yorkshire 0-19 Children's services.

- An event had been held to celebrate the contribution made over many years to the Trust by the Friends of Harrogate Hospital, and she had also attended the AGM of the Friends of Ripon Hospital.

5.0 Report by the Chief Executive

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

5.2 Mr Russell drew the Board's attention to the following key issues outline in his report: progress with the transformation programme, the Trust's performance at the end of Q1, progress with the Pathology Joint Venture, and the People Plan. The Board were advised of the latest information about EU Exit, and the work on planning for flu season which would be discussed at the next Board workshop.

5.3 Some of the achievements of colleagues in the Trust were highlighted with attention drawn to the Children's 0-19 services and the breadth of their work. He and the Chairman had presented the Trust Long Service Awards and he remarked that it was unusual for so many to have worked for so long in one place – 26 for their entire NHS careers. He particularly mentioned Monica Sharpe who had worked for the Trust (and its forerunners) for 50 years. The Active against Cancer service had launched and had attracted 50 referrals in the first two weeks – patients and families had been very complimentary and had already formed social connections around health and wellbeing, not just their disease.

5.4 Finally, Mr Russell asked Board members to note the updates on the Corporate Risk Register and the Board Assurance Framework.

5.5 Ms Robson described it as a great report; she said that the Quality Committee had discussed complaint response times and she said that Mr Russell's personal focus on the timeliness and quality of responses was welcome and very helpful. She asked about the materiality of the Pathology JV business case. Mr Russell said it would have been either material or significant, in the latter case for financial reasons or because it was novel and contentious. The classification as material meant the Trust could execute the transaction without further review by NHSI/E. The decision would need to be reported to the Council of Governors.

5.6 Mr Alldred was very pleased to read the section of the report on celebrating success; it was hugely positive and needed to be shared widely. It was important for staff to see that these successes were recognised at Board level. Mr Coulter said that more successes need to be captured, perhaps through the Making a Difference awards.

5.7 Mrs Schofield said that the report had great value because it had been written in Mr Russell's own words. It would be shared, routinely, with Governors from now on.

5.8 Mr Stiff noted the risk around not being able to access historical e-mails when the Trust moves to NHS.net (CR38.) Mr Harrison said that high volume users and those requiring access to archived e-mails would retain Outlook, which would allow access to archived files and this removed the risk.

5.9 Mrs Schofield was concerned about the position with breast cancer referrals. Mr Harrison said that the standard had been missed significantly, although the waiting time had improved from 27/28 days to 19 days; the standard was 14 days. He said work was in hand to return to the standard by October. Mrs Schofield noted that CR27 would change once the Provider Sustainability Funding (PSF) had been received and she said that the

Trust was developing a plan around the pensions issue (CR37). Mr Thompson asked about the DHSC consultation and Ms Wilkinson confirmed that it had opened the week before and would close in mid-October.

5.10 Mrs Webster asked about support funding from NHS England and Mr Coulter said that he was confident that the funding would be provided to the CCG. Mr Russell noted that the CCG was paying the Trust in 1/12ths of the agreed contract sum despite the £4m not having been released.

5.18 Mrs Mayfield confirmed that there would be a recruitment event for healthcare support workers in mid-August. She said that there had been 12 cases of *Clostridium difficile* to date, against an annual threshold of 19; two of the cases for which analyses had been completed had been due to lapses in care.

5.19 Mrs Schofield reported that Dr Child had resigned as the Director of Infection Prevention and Control and Mrs Foster would undertake this role. Mrs Mayfield reported that the last case of flu had been reported on 19 March and that planning for the 2019-20 campaign was underway. The Trust had been commended by Public Health England (PHE) for the hepatitis A vaccination campaign mounted in Ripon after 30 cases had been detected. One secondary and three primary schools had been involved and there had been no further cases since 18 July. Dr Lyth added that staff had been diverted from the Children's 0-19 service to assist and this demonstrated good relationships in community services. Answering Mr Thompson she said that 75% of the children had been vaccinated, all with consent which was a good result in such a short timescale. The contribution of pharmacy was noted and it was confirmed a lessons learnt exercise would be undertaken.

5.20 In answering a question from Mrs Schofield, Mr Harrison said that the Infection Prevention and Control Committee had set up a special group, under Mrs Foster, to examine the situation with *C. difficile.* It would report on the cases to date and the background.

To deliver high quality healthcare

6.0 Quality Committee Report – 3 July 2019

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

6.2 Ms Robson drew attention to the meeting about respiratory audits. She said that the respiratory team was both innovative and committed but was a team under pressure. The head of the Resuscitation team had attended the meeting to discuss the ResPECT programme and it remained high on the Committee's agenda.

6.3 Mr Alldred said that the whole respiratory medicine service was under review; an additional consultant and an Advanced Care Practitioner would start in September/October; He noted that whilst the service was under pressure, patients are seen on time and advised that the service had found the Committee meeting helpful and supportive. Dr Scullion noted that the visit by the Getting It Right First Time (GIRFT) team had found lots of positives and its report would be used as a basis for improvement – the quality of staff had been commended. Ms Armstrong added that the team was dynamic and good at finding workarounds. There was further discussion about the value of the GIRFT visit, the workload imposed by national audits and assurance that the service was safe and sustainable. Ms Robson confirmed that the Quality Committee would continue to seek assurance.

6.4 Responding to concerns about the Trust's response to the Respect programme, Dr Scullion said that the different interests and views needed to be brought together, for the benefit of both clinicians and patients. Mr Russell said that this subject had been on the Quality Committee and Board agendas for some time and recommended that the Board receive a formal paper describing the component parts of RESPECT and other programmes, and setting out how the Trust is meeting each part and to highlight any gaps along with a plan.

Action: Dr Scullion to bring forward proposals to Quality Committee and Board of Directors around End of Life pathways and assessment of Respect and Trust policies and gaps.

7.0 Annual Efficiency Quality Impact Assessment

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

7.2 Mrs Webster noted that this process provided assurance at Directorate level and it was important to capture multiple effects at Board level to give a Trustwide view under Gateway 2 although she felt that Gateway 2 needed to have a better descriptor. Mr Stiff agreed that the process was satisfactory but that it should provide assurance to the Board rather than the Quality Committee. Mr Coulter noted that the Board needed to decide how to demonstrate that the expected impact of measures had taken place and Mr Harrison suggested this should be through the Quality Committee and included in the IBR.

7.3 In summary Mr Russell said that the quality impact assessment process was working well and that the future Board reports should focus on schemes with an unanticipated adverse effect. Mrs Schofield agreed and suggested that it will take until May 2020 to determine the actual impact of the schemes.

8.0 Operational Performance Report

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

8.2 Mr Harrison drew attention to the transformation work with HaRD CCG which was underway. There had been a reduction of 17% year-to-date in referrals from Leeds CCG, following a change to the commissioning process. This was a significant risk and was resulting in a financial risk of £2m, should it continue. Meetings with Leeds CCG were scheduled. As a consequence the Trust was accelerating the treatment of HaRD CCG patients beyond the agreed activity level. The changes to Gynaecology referrals (which had fallen by 15%) have been reversed, and General Surgery (15%) and Urology (36%) were being redirected manually.

8.3 Mrs Schofield asked whether it would be possible to recoup the lost income and Mr Harrison said that this was unlikely for Quarter 1. Mr Russell confirmed that there were also meetings with Leeds CCG to try and resolve the situation. Mr Coulter confirmed that the Trust was considering reducing costs and capacity to try and match the reduced referrals.

8.4 Mr Harrison noted that the bowel screening programme national level had been set too low and the programme was currently running at 97% above plan. The Trust has capacity and funding is being sought from NHS England.

8.5 The Trust has been selected as a trial site for the Elective Clinical Review of Standards. As of 1 August (and for the four succeeding months) the Trust would report in a different way against the 92% RTT target, and would pilot new standards, whilst helping to shape future national reporting requirements.

9.0 NHS Resolution Maternity Incentive Scheme – year 2 Report

9.1 The reports had been circulated in advance and were taken as read.

9.2 Mr Harrison advised that he and Mrs Foster chaired a monthly oversight meeting which examined the elements of the report and checked that the actions required were delivered and Ms Robson said that some of the reports had been brought to the Quality Committee.

9.3 Dr Johnson reported that in 2018/19 the Trust had been compliant on six standards. The actions put in place allowed the Trust to declare that it was fully compliant in 2019/20.
The Board was then taken through the detail of each of the Maternity Safety Actions, with Board members asking questions on each in turn.

In response to a question, Dr Johnson advised that the number of Caesarean sections carried out was average when standardised, but high when unstandardized

9.4 After detailed discussion, The Board approved the year 2 Maternity Incentive Scheme safety actions 1, 4, 5, 6 and 7 and the submission of compliance to NHS Resolution. Dr Johnson noted that some of the reduced premium should be reinvested in Maternity to continue improvement. Ms Robson confirmed the Quality Committee would continue to ensure compliance was scrutinised.

APPROVED:
The Board of Directors approved the year 2 Maternity Incentive Scheme safety actions 1, 4, 5, 6 and 7.

10.0 Medical Director Report

10.1 Dr Scullion gave a verbal report. He recommended Board members read the annual Research and Innovation Report, which he had placed in the Reading Room on Diligent. He reported that the Hospital Standardised Mortality Ratio currently stood at 103 and the Summary Hospital-level Mortality Indicator was also below the national average.

10.2 Following a review of nine cases of pathological fractures, Dr Scullion said that no lapses in care had been found, although there had been coding issues.

To ensure clinical and financial sustainability

11.0 Finance Report

11.1 The report providing an overview of the Trust position for Quarter 1 of 2019/20 had been circulated in advance of the meeting and was taken as read.

11.2 Mr Coulter advised the Board that the position at the end of Quarter 1 was a £2m deficit and that the Trust qualified for £414,000 of Provider Sustainability Funding (PSF). He outlined particular risk around the Leeds position, which had been covered earlier, the transformational schemes, delivery of the CIP and the HIF dividend.

11.3 His forecast was that in the best case the Trust plan would be delivered. The Trust would declare a Use of Resources rating of 3, as planned. £6m of PSF from the last financial year had been received in July and this had improved the cash position. The Resources Committee had looked in detail and the Senior Management Team would also be examining the forecast – he considered that the Trust needed to 'turn the corner' in the autumn if the plan was to be achieved.

11.4 Mr Coulter informed the Board that the new Directorate Resource Group meetings were proving to be very successful, with the right level of debate.

12.0 Summary from Resources Committee meeting of 29 July 2019

12.1 The update report had been circulated in advance and was taken as read.

12.2 Mrs Taylor reported that in June the Committee had examined in detail the private patient plan and been assured that the forecast was ahead of plan. At the July meeting there had been discussion about the Leeds/HaRD CCG activity. The Committee heard that the Trust was 28 WTE staff behind planned levels and that a planned recruitment event for Care Support Workers in mid-August should reduce the agency spend on these staff. Receipt of the PSF had eased the payments position. There had been discussion about the capital position, which would be covered later in this meeting. The Committee had received presentations from Mr Hammond and Mr Forster around the transformation programme, which would be subject to monthly reviews. The main risk clearly lay in the Leeds referral situation and the capital programme.

12.3 Ms Robson asked about the financial risk around HIF and Mr Coulter, having declared his interest, said it related to the planned dividend of £200,000 HIF was behind plan and this was therefore at risk. Mr Thompson, who had also declared his interest, said the issues were in relation to the CIP and equipment, as well as clinical waste; but noted that labour costs were below plan and assured the Board that the HIF team were focused on improvements.

12.4 In conclusion, Mrs Taylor said that the momentum needed to change in Quarter 2 to turn round the financial position.

13.0 Capital Investment Programme Update

13.1 The paper had been circulated in advance and was taken as read. Mr Coulter noted that the Trust had been asked to reduce its capital plan. Originally it had stood at 2% of turnover (compared with 3% across the ICS). The reduction meant the planned spend was now below retained depreciation. The Trust was proposing to 'make best endeavours' but in the event that essential capital spend was required then it would proceed. The

reduction in the capital programme would be achieved by deferring rather than cancelling projects. This was therefore a risk as the Trust did not have assurance that further national funding would be forthcoming. It was recommended that the Board sign off the revised plan, with reluctance; noting that after discussion the Resources Committee had agreed this recommendation.

13.2 The Board expressed concern and frustration. Mrs Taylor believed that there would be slippage but asked if there should be any rebalancing across the Trusts. Mr Russell said that it had ben emphasised to NHSI that HDFT's capital programme was for replacement equipment or backlog maintenance. The Trust would write to NHSI outlining the Board's position and the situation would be reviewed in November or December.

13.4 Mrs Schofield said that she would be a co-signatory of the letter which would go to NHSI to reflect the unanimity of the Board The Board approved the revised capital programme for 2019/20.

APPROVED:
The Board of Directors approved the revised capital programme for 2019/20.

14.0 Summary of the meeting of the Pensions Committee meeting on 26 June 2019

14.1 The summary had been circulated in advance and was taken as read.

14.2 All members of the NHS Pension Scheme declared their interest in the matters under discussion and it was agreed that they could contribute to the discussion. Mrs Schofield said that the Committee had been very concerned about the effect of withdrawals from the NHS Pension Scheme, a significant number of which were not related to the Lifetime or Annual Allowance. The Trust should ensure that staff have access to good pensions advice, especially if they were contemplating leaving the NHS Pension Scheme.

14.3 Dr Scullion drew attention to a factual error in the summary – the Annual Allowance was £40,000 not £50,000 and suggested alternative a more accurate wording in paragraph 8, which was accepted by the Board. Dr Johnson felt that the wording regarding risk in the cover sheet did not reflect the position accurately. She hoped that the position could be revisited at some point and referred to Corporate Risk CR37.

14.4 Mrs Schofield reported that the Committee had agreed to terminate the Lifetime Allowance – Pension Restructuring Policy and not to proceed with restructuring around the Annual Allowance.

15.0 Workforce and Organisational Development Report

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

15.2 Ms Wilkinson said that the practice around the Fit and Proper Persons Test had been reviewed and the changes included individuals discussing with their appraisers annually whether there had been any material changes to their position. It was queried whether Governors should be included and it was agreed this should be considered further.

15.3 Ms Robson asked whether the turnover figures had increased and were they around average. Ms Wilkinson reported that the Resources Committee had asked to see more information, to identify trends and especially those driving up demand for agency or bank staff. Turnover at 12% was around average and anything above that would need to be reviewed more closely.

15.4 With regard to the Workforce Race Equality Standard report Ms Wilkinson said that

there had been improvements in three specific areas and her report contained a brief summary.

15.5 Mr Thompson noted that comparison with last year could be confused by the inclusion or exclusion of HIF staff. Ms Wilkinson agreed to clarify the figures at the September Board meeting.

15.6 In respect of the Workforce Disability Equality Standard report Ms Wilkinson said that there could be undeclared disabled staff and more work was required but the report provided transparency around this issue for the first time.

15.7 Mrs Schofield asked about the next steps – Ms Wilkinson said the data would be submitted and that SMT would review the insight and agree appropriate actions, supported by the Workforce Equality Steering Group. A report would be brought back to the Board.

Action: Ms Wilkinson to clarify position of HIF staff to allow accurate year on year comparison

Governance

16.0 Board of Directors Terms of Reference Review

16.1 The draft Terms of Reference had been circulated in advance of the Board meeting and were taken as read. The draft contained minor changes.

APPROVED: The Board of Directors approved the revised Terms of Reference.

17.0 UCI World Cycling Championships 2019

17.1 The paper had been circulated in advance of the meeting and was taken as read. There was a discussion about various aspects including the effect on the delivery of services and access to the hospital for staff and patients throughout the extended period. Mr Russell advised that he had met the Chief Executive of Yorkshire 2019 to discuss key issues from the Trust's perspective and to support the event.

17.2 Mr Harrison noted that the Board of Directors would have a discussion at the August Board workshop but sought Board agreement to delegate signing off the UCI 2019 Health and Social Care Plan once it had been agreed at the Harrogate A&E Delivery Boards in early August.

AGREED; The Board of Directors agreed to delegate signature of the UCI 2019 Health and Social Care Plan to Mr Russell and Mr Harrison.

18.0 Any other relevant business not included on the Agenda

There was no other business not included on the Agenda.

19.0 Board Evaluation

Board members agreed that the agenda for the meeting had been extensive and this had affected the timing. The time taken to consider the maternity reports had been worthwhile as there was much detail but it had been good news. It was more helpful to discuss than just to review papers and the Patient Story had been valuable as a learning opportunity.

20.0 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 1.20pm.

Harrogate and District NHS Foundation Trust

4

HDFT Board of Directors Actions Schedule
Action Log
September 2019

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

Ref	Meeting Date	Item Description	Director/Manager Responsible	Completion date	Detail of progress
81	January 2018	Further consideration to include additional metrics, change of style, inclusion of issues around AIC and patient experience in adult and children community services	Mr Harrison, Chief Operating Officer / Mr Alldred, Clinical Director LTUC / Dr Lyth, Clinical Director CCWCC	**November** 2019	
130	January 2019 (minute 17.2)	Post Project Evaluation of Supported Discharge Service to be considered by Board of Directors	Mr Harrison, Chief Operating Officer	November 2019	
131	March 2019 (minute 6.4)	Quality Committee to consider issues underlying FFT results	Ms Robson, Non-Executive Director, Chair of Quality Committee	**September** 2019	*From May 2019*
136	May 2019 (minute 5.11)	Programme discussion of implications of CCG merger at future Board workshop	Mr Forsyth, Interim Company Secretary	September 2019	Awaiting further details of merger
138	May 2019 (minute 8.3)	Facilitate presentation of business case for e-rostering system to Senior Management Team	Mr Coulter, Director of Finance	September 2019	Possible external source of funding
140	May 2019 (minute 9.4)	Update Board on progress to improve Trust complaints process	Mrs Foster, Chief Nurse	September 2019	
141	May 2019 (minute 10.2)	Details about maternity and paediatric deaths to be added to quarterly Learning from Deaths report	Dr Scullion, Medical Director	September 2019	
144	May 2019 (minute 15.4)	Programme discussion to explore connection between Trust policies and fair and just culture	Mr Forsyth, Interim Company Secretary	August 2019	Board workshop
145	July 2019 (Patient Story)	Write to mother featured in Patient Story	Mrs Schofield, Chairman	September 2019	
146	July 2019 (Patient story)	Ensure positive feedback on her performance given to mother's ante-natal midwife	Mr Alldred, Clinical Director LTUC	September 2019	

1

You matter most

147	July 2019 (minute 6.4)	Bring forward proposals to Quality Committee and the Board of Directors around End of Life pathways and assessment of Respect and Trust policies, and gaps	Dr Scullion, Medical Director	September 2019	
149	July 2019 (minute 15.5)	Clarify whether comparator figures 2018-19 and 2019-20 for WRES include HIF staff or not, to allow accurate year on year comparison	Ms Wilkinson, Director of W&OD	September 2019	

Harrogate and District NHS Foundation Trust

5

Date of Meeting:	25 September 2019	**Agenda item:**	5.0
Report to:	Board of Directors		
Title:	Report by the Chief Executive		
Sponsoring Director:	Mr Steve Russell, Chief Executive		
Author(s):	Mr Steve Russell, Chief Executive		
Report Purpose:	**Decision**		**Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓
Executive Summary:	• NHSE/I have confirmed the £6m funding for the HaRD CCG to support the transformation programme; • At the end of Month 5, the Trust remained on plan for finance but has a number of significant risks; • NHS England and NHS Improvement has also confirmed that the Trust can now return to its original capital plan of £5m provided this is funded internally; • The Trust is partially compliant with the EPRR standards • Significant changes in the complaints processes will follow the recent RPIW.		

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

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

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

Harrogate and District NHS Foundation Trust

Operational & Financial Performance

1. There continues to be progress on the transformation programme with changes to pathways being introduced in a number of specialities. However, translating this into a reduction in cost is challenged by a number of factors; (1) The level of non-elective demand growth is significantly higher than had been anticipated meaning that is becoming difficult to contain growth within the historical cost base; (2) There is a time lag in the changes to elective pathways taking place impacting on activity level; and (3) The change in the referrals from Leeds CCG has meant that the balance of activity has shifted towards Harrogate and Rural District (HaRD) CCG resulting in overperformance.

2. Through the joint programme board, actions are being taken which aim to mitigate the risks associated with this but it is important that we continue the work as it will ultimately bring medium term benefits.

3. NHS England and NHS Improvement attended the last programme board and gave positive feedback on progress, noting the risks and have confirmed the full £6m of support will be made available to HaRD CCG.

4. West Yorkshire & Harrogate ICS receives c£8m of transformation funding in 2019/20. As part of the 2019/20 agreement between the Trust, CCG, ICS and NHS England/NHS Improvement it was agreed that the CCG would receive £0.7-1m of transformation funding. The share of the Urgent Care funding has now been allocated and Harrogate will receive c£0.3m. This is being used to fund the continuation of the transformation schemes such as SDS.

5. Activity with HaRD CCG is therefore higher year-on-year and against plan across all types of activity except elective in-patients. To date, this has been accommodated in the overall Trust's planned spend through non-recurrent means but is causing pressures within the clinical directorates. The overperformance to date is over £1.2m, and based on our risk-share the maximum the Trust could access to date is £0.6m. At this stage, we continue to aim to meet our control total without the need for the risk share funding.

6. At the end of Month 5, we remained on plan for finance but have a number of significant risks. These are Income from Leeds CCG, Agency and Medical staffing overspends and NHS property services. The worst case scenario is a £5m risk for the year, with a mitigated risk of £2m.

7. These risks were discussed in detail at SMT and Resources Committee and recovery plans focused on waiting list initiative spend, winter investment, agency controls and NHS property services funding have been developed to reduce the in-year risk. This is covered in more detail in the Director of Finance's report.

8. The Trust has received confirmation from NHS England and NHS Improvement that the Trust can now return to our original capital plan of £5m provided this is funded internally. This is clearly dependent upon delivery of our overall financial plan and mitigating the risks to our revenue position.

9. We are taking the opportunity to revisit the capital programme and to undertake a refresh with a top-down (driven by asset register data on equipment at end of life) and a review of the bottom-up approach which has been used to date to ensure there are no material omissions and that capital spend is directed appropriately.

10. The Trust is a pilot site for the proposed new elective care (RTT) waiting time standards and as a consequence we have paused reporting of the 92% measure during the trial. We will continue to report total waiting list size and the number of 52 week waits. The change in reporting is required and mandated by NHS England and NHS Improvement during the trial.

11. The adverse variances in the Integrated Board Report (IBR) relate to Falls, reporting of low/no harm incidents (Safe), SIRIs, waiting times for A&E, elective care, first outpatient appointment for suspected cancer referrals and 62 day waiting times for screening services (Responsive), sickness (Workforce), and a deficit run rate (Finance). Additional detail is provided in the respective Director reports.

12. The NHS Long Term Plan requires systems to produce assumptions on activity, finance and workforce. A draft submission has been agreed between HaRD CCG and the Trust with the final deadline being 1 November 2019.

13. The medium term financial review of the Harrogate place has now commenced, with work taking place up to a series of system workshops to share the findings and develop proposals for change.

EPRR annual assurance

14. The annual assurance on Emergency Preparedness, Resilience and Response is being presented in full during the private session of the Board meeting and will include the declaration of partial compliance with the national assurance framework. This is the same compliance as last year although the Board should note that the standards have moved on and the actions from last year have been carried out. There is a further new action plan for the forthcoming year.

North Yorkshire 0-19 service

15. NYCC has made a decision that they wishes to enter into a long term partnership over 10 years with HDFT to provide the 0-19 service across North Yorkshire. Discussions are ongoing and we will continue to brief the Board and Council of Governors.

16. Following the recent spending review it was announced the public health grant would grow in real terms in 2020/2021 although the changes at a Local Authority level are not yet known.

Complaints & learning from experience

17. The RPIW for complaints has taken place with very strong engagement from colleagues with a goal of putting learning at the centre of the process, supporting colleagues where complaints arise, and sharing our findings and learning in a prompt manner. A significant number of changes are planned and the new process will launch in November.

18. Incremental progress is being made in improving the timeliness of responses to questions or concerns raised by patients and their families with the number of overdue responses falling. We have introduced new reporting measures to show progress against the median and 95th centile times which shows how long it takes us to respond to 95% of complaints.

19. Only 39% of complaints received in 2019/20 have been responded to within 25 days. However, there has been a positive reduction in the total time to response. In 2018/19 95% of complaints were responded to in 82 days or less, with 50% within 36 days, with the average being 40 days. In 2019/20 95% of complaints have been responded to within 60 days or less, 50% in 29 days or less and the average is 31 days.

20. Whilst there is further improvement needed in order to meet the standard we have set, the 'length of delay' has reduced.

teamHDFT 'people' plan

21. A number of key elements of this work have now started. The first two cohorts of the 'first line leaders' programme have commenced with 48 participants and the pilot of learning partners for the RCN clinical leadership cohort and the Executive Team has commenced.

22. Work continues to progress on the introduction of a 'Shadow SMT', a 'Shadow Board' and support is being provided to Directorates to help further develop the way in which the Operational Boards work.

23. The second phase of the Deloitte work on fair and just culture is due to start in September and will focus on a more in-depth review of a small number of themes and services.

Equality, Diversity & Inclusion and "Talk to me"

24. Angie Colvin has been appointed as the Trust's lead for Equality, Diversity and Inclusion on a one year secondment. A number of pieces of work have been launched which are being framed under the overarching message of 'Talk to me' which is focused on supporting an open and inclusive culture in which everyone feels welcome (patients, relatives and HDFT colleagues).

25. The Rainbow Badge initiative has been launched with colleagues offered the opportunity to make a pledge to support inclusion and champion equality and diversity and to show this by wearing a Rainbow Badge. Our Board have all signed their pledges and are wearing their badges, and to date over 637 pledges have been signed; in the first 3 days over 500 pledges were made.

26. We have launched some promotional materials across the Trust to celebrate the broad make up of HDFT and HIF – branded 'one teamHDFT, 58 nations' to reflect and celebrate the 1 in 10 colleagues who bring their experience and expertise from 58 countries to HDFT and HIF.

Eat, Move, Improve

27. Supporting our patients to eat well, drink well and mobilise is a key part of our role in supporting their recovery. Many studies show the positive impact of these three interventions in recovery and wellbeing.

28. Our therapy and nursing teams have put together a programme of work which will support this, and it launched the week of 2nd September on Byland Ward. There is an important opportunity for volunteers to be trained to support this programme of work

alongside it being a key focus for every colleague in HDFT as part of our focus on the health and wellbeing of our patients.

#Cleartheclutter

29. There is a widespread desire to improve the appearance of HDH in particular and our 'Improving the Hospital Environment' group has been making good progress to reduce the clutter in departments and on the hospital corridors as well as to refocus attention on the importance of a professional looking environment.

30. As expected, this work is identifying a number of system and process issues which lead to the current situation and whilst some tactical solutions are being implemented to make more immediate improvements we are running an RPIW in November which will focus on the overall process and system improvements that are needed.

31. Alongside this, we are starting work to improve wayfinding and signage, to consider how to improve the appearance of the flooring, ceiling tiles and the general cleanliness of the hospital as well as developing a programme to update the decoration. In the more medium term work is being undertaken to identify how to improve storage which remains a key challenge, particularly in ward environments.

Celebrating Success

33. The Trust received a "Top 40 Hospitals" award from CHKS reflecting the hard work of colleagues.

34. The formal launch of Active Against Cancer took place with widespread press coverage showcasing and promoting the importance of exercise.

35. Our Growing Health Stockton team have developed an app which will help children and families to access advice and resources about living health lifestyles.

36. We ran a number of opportunities for visitors, patients and colleagues to have their blood pressure checked as part of "Know your numbers" for the national blood pressure week.

37. After a significant fundraising effort, supported by the Friends of Harrogate Hospital, the RetCam was handed over to the Ophthalmology department.

38. Our Growing Healthy team in North Yorkshire won a national award for their work in developing a support group for anxious mums.

39. Our organ donation team supported Organ Donation Week by sharing stories about the impact organ donation can have, and sharing information about the upcoming change in the law.

40. Our photo competition secured over 200 entries of photos representing what HDFT stands for, the people who make it up and the places we work. A number will be displayed across our sites.

41. The redecoration of our Children's ward (Woodlands) has completed its next stage following on from the upgrade to Children's outpatients and plans continue to be developed for improvements to the outside play area.

Harrogate and District NHS Foundation Trust

UCI

42. The UCI cycling event takes place in September. The Trust has undertaken extensive preparations for the week and has recently met with the CEO of Yorkshire 2019. Yorkshire 2019 have kindly donated 25 Sportive places which the Trust has given to Active against Cancer to 'auction' for donations to HHCC and Action Against Cancer.

43. The cost to HDFT of UCI/Yorkshire 2019 is estimated at up to 0.5m. No funding support has been made available to the Trust which is very disappointing given our emergency preparedness obligations. This is one of the financial risks facing the Trust.

Corporate Risk Register

44. The Corporate Risk Review Group met on 13 September under the chairmanship of Mr Harrison. The Group reviewed all the risks recorded on the Corporate Risk Register and, in addition, reviewed the Directorate Risk Registers. The following summary of the Corporate Risk Register records the current position:

Ref	Description	Current risk score	Risk movement	Current progress score	Target date for risk reduction	Notes
CR2	Risk to the quality of service delivery in Medicine due to gaps in rotas; reduction in trainee numbers; agency cap rate; quality control of locums; and no-deal EU Exit *(added 08/03/2019)*.	16	↔	*3*	*Mar-20*	
CR5	Risk to the quality of service delivery due gaps in registered nurses establishment	12	↔	*2*	*Oct-20*	
CR14	Risk of financial deficit and impact on the quality of service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income. *NB Impact of no-deal EU Exit on annual financial plan added 08/03/2019*	12	↔	*2*	*Mar-20*	
CR18	Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down	12	↔	*1*	*Aug-20*	
CR26	Risk of inadequate antenatal care and patients being lost to follow up - due to inconsistent process for monitoring attendance at routine antenatal appointments in community	12	↔	*2*	*Oct-19*	
CR32	Financial risk from major sporting events due to cost of contingency arrangements and loss of income	12	↔	*3*	*Sep-19*	
CR34	Risk to quality of care by not meeting NICE guidance in relation to the completion of autism assessment within 3 months of referral.	12	↔	*1*	*Oct-19*	
CR37	Risk of negative impact on performance targets, income and potentially patient safety if individual consultants/SAS doctors reduce job plans/additional activity as a result of tax changes in 2019.	9	↓	*5*	*Apr-20*	*Risk removed September 2019*
CR40	Risk to the quality of service delivery due to the clinic capacity of the one-stop service - breaching 2WW times; risk of complaint; non-compliance with national standards; critical report; low performance rating due to significant daily breaches of the breast 2WW times	9	↓	*2*	*Oct-19*	*Risk removed September 2019*
CR41	CR41 Summary RTT risk - Risk to patient safety, performance, financial performance and reputation due to increasing waiting times across a number of specialties	12	↔	*tbc*	*tbc*	*Risk re-described to encompass broader risks*
CR42	Risk that staff are not able to access IT systems due to Cyber Security attacks or issues with the WIFI network	12	↔	*tbc*	*tbc*	

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

45. No new risks were added to the Register. Two risks (CR37 and 40) have been removed from the Register and elements of both risks were reflected in CR41, which was re-described to encompass the wider risk from extended waiting times for patients. This revised risk will be considered as potential strategic risk at the next review of the Board Assurance Framework.

Board Assurance Framework

46. The Board Assurance Framework was reviewed in detail during early September. No risks were added and none removed at this review, although a number of new Key Controls and mitigating actions were defined. The following summary of the Board Assurance Framework records the current position:
The summary of strategic risks to the Trust, as reflected in the Board Assurance Framework, is as follows:

Ref	Description	Risk score	Progress score	Target risk score reached
BAF 1	Risk of a lack of medical, nursing and clinical staff	*Amber 9 ↔*	*Unchanged at 1*	√
BAF 2	Risk of a high level of frailty in the local population	*Amber 8 ↔*	*Unchanged at 1*	√
BAF 3	Risk of a failure to learn from feedback and Incidents	*Amber 9 ↔*	*Unchanged at 2*	
BAF 5	Risk of maintaining service sustainability	*Amber 9 ↔*	*Unchanged at 1*	
BAF 9	Risk of a failure to deliver the Operational Plan	*Red 12 ↓*	*Unchanged at 2*	
BAF 10	Risk of breaching the terms of the Trust's Licence to operate	*Yellow 5 ↔*	*Unchanged at 1*	√
BAF 12	Risk of external funding constraints	*Red 12 ↔*	*Unchanged at 1*	√
BAF 13	Risk standards of care and the organisation's reputation for quality fall because quality does not have a sufficient priority in the Trust	*Yellow 4 ↔*	*Unchanged at 1*	√
BAF 14	Risk of delivery of integrated models of care	*Amber 8 ↔*	*Unchanged at 1*	√
BAF 15	Risk of misalignment of strategic plans	*Red 12 ↔*	*Unchanged at 1*	
BAF 16	Risk that the Trust's critical infrastructure (including estates, diagnostic capacity, bed capacity and IT) is not fit for purpose	*Red 12 ↔*	*Unchanged at 2*	
BAF 17	Risk to senior leadership capacity	*Amber 8 ↔*	*Unchanged at 1*	

Harrogate and District NHS Foundation Trust

Sealing of Documents

47. Since the last Board meeting the Chairman and I are pleased to have signed and sealed the following documents:

- Lease in respect of York NHS Foundation Trust's ground floor Heatherdene dialysis unit until April 2023 with a break date on the 3rd anniversary;
- Lease in respect of York NHS Foundation Trust's 1st floor Heatherdene GUM/CASH Clinic accommodation until April 2023, with a break that in the event of York no longer being the service provider the lease will surrender co-terminously;
- The Clinical Services contract between the Trust and Integrated Pathology Solutions Ltd;
- The Deed of Variation of the Managed Laboratory Services Agreement between Airedale NHS FT, Bradford TH NHS FT, Integrated Laboratory Solutions LLP and the Trust;
- The Deed of Variation of the Pathology Services contract between Airedale NHS FT, Bradford TH NHS FT, Integrated Pathology Solutions LLP and the Trust;
- The Deed of Adherence and Amendment and Restatement in relation to the members' agreement dated 7 February 2017 relating to Integrated Laboratory Solutions LLP and
- The Deed of Adherence and Amendment and Restatement in relation to the members' agreement dated 7 February 2017 relating to Integrated Pathology Solutions Ltd.

Steve Russell
Chief Executive **September 2019**

Harrogate and District NHS Foundation Trust

Integrated board report - August 2019

Key points this month

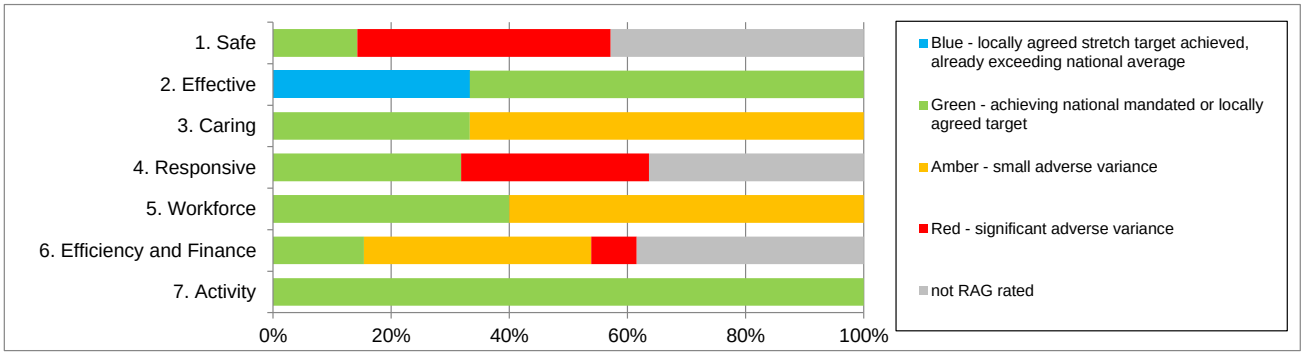
1. The Trust reported a deficit position in August of £640k. This was £132k adverse to plan. This deficit position increased the year to date deficit to £2,314k.

2. HDFT's performance against the A&E 4-hour standard was below 95% reported at 91.4%.

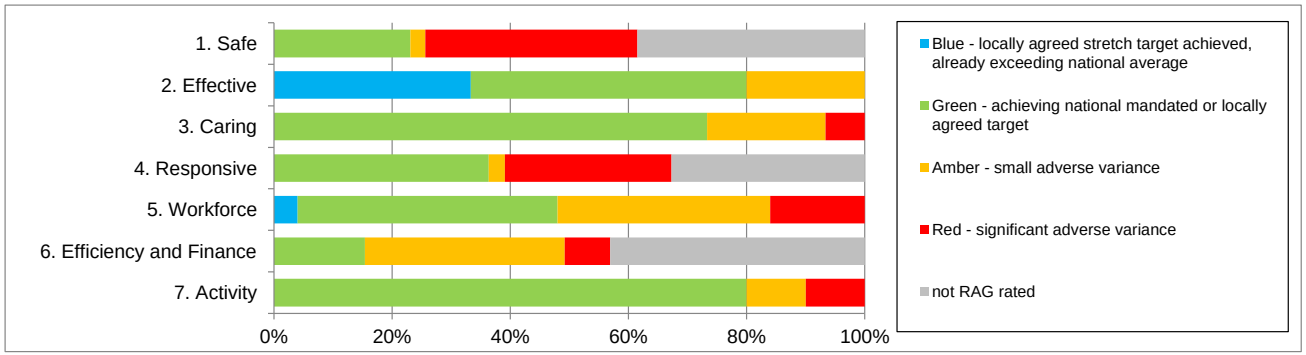
3. RTT - the total number of patients waiting at the end of August was 15,387. This is below the trajectory of 16,244.

4. Provisional data indicates that 4 of the 8 cancer waiting times standards were achieved in August, with the 14 day breast symptom, 62 day wait, 62 day Screening, and Surgical subsequent treatement standards not delivered. Performance against the 14 day suspected cancer standard was delivered in August for the first time since March 2019.

Summary of indicators - current month



Summary of indicators - year to date



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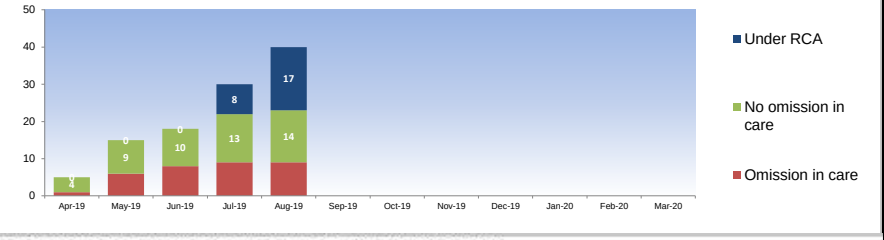
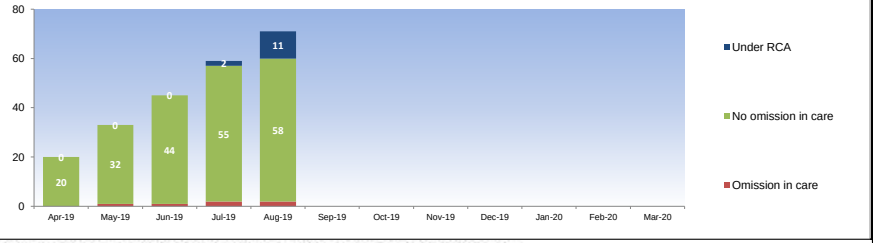
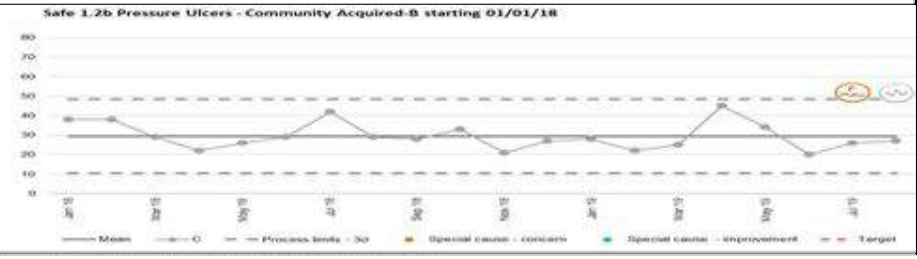
Section 1 - Safe - August 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.1a	Pressure ulcers - hospital acquired DQ		There were 10 hospital acquired category 3 and above pressure ulcers reported in August (including device related and device related mucosal). This is higher than last year with an average of 6 per month reported in 2018/19. Of the 10 reported there were 0 omission in care, 1 no omission in care and 9 under RCA.
1.1b	DQ		The number of hospital acquired category 2 and above pressure ulcers reported in August was 34. The reported number is inclusive of device related and device related mucosal pressure ulcers.
1.2a	Pressure ulcers - community acquired DQ		There were 12 community acquired category 3 and above pressure ulcers reported in August (including device related and device related mucosal). The average per month reported in 2018/19 was 11. Of the 12 reported there were 3 no omission in care and 9 under RCA.
1.2b			The number of community acquired category 2 and above pressure ulcers reported in August was 27. The number reported is inclusive of device related and device related mucolsal pressure ulcers.

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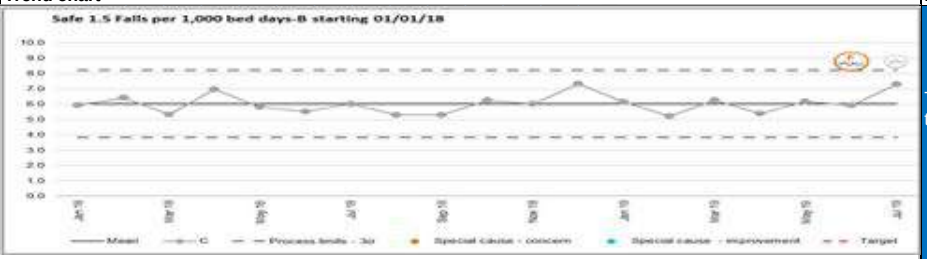
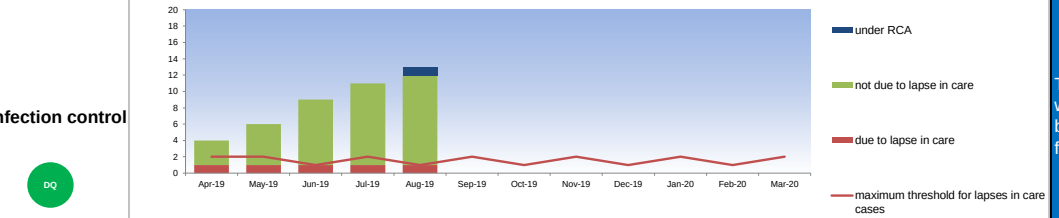
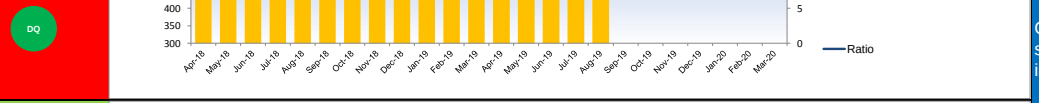
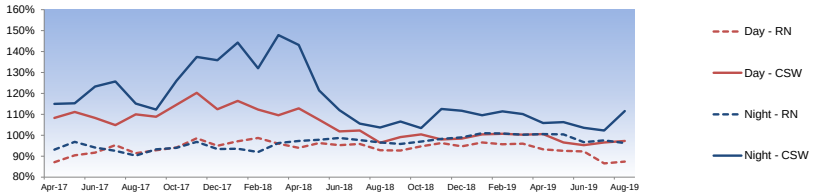
Section 1 - Safe - August 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.3	Falls 		The rate of inpatient falls was 7.31 per 1,000 bed days in July. This is higher than the average HDFT rate for 2018/19 (6.01)
1.4	Infection control 		There were 2 cases of hospital apportioned C. difficile reported in August one of which was not due to a lapse in care and one uder RCA. No MRSA cases have been reported in 19/20. The annual maximum threshold for lapses in care cases for 2019/20 is 19.
1.5	Incidents - all 		The latest published national data (for the period Apr 18 - Sept 18) shows that Acute Trusts reported an average ratio of 46 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's published ratio was 22, an increase on the last publication but remaining in the bottom 25% of Trusts nationally. HDFT's latest local data for August gives a ratio of 14, a slight increase on the July position of 12. CCCC is continuing to focus on its reporting culture. There are now 4 DATIX super-users and a focus on reporting and learning. CCCC is showing improvements in its reporting culture and there is a focus on response rates.
1.6	Incidents - SIRIs and never events 		There was one comprehensive SIRI in June and one in July but no Never Events were reported for the quarter. No Never Events were reported in 2017/18 or 2018/19. There were no SIRIs in August.

Harrogate and District NHS Foundation Trust

Section 1 - Safe - August 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.7	Safer staffing levels 		In August staff fill rates were reported as follows: Registered Nurses Day 87.4% and Night 96.2%, Care Staff Day 97.2% and Night 111.6%. Reported care hours per day per patient was 7.95 hours per day.

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Harrogate and District
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Section 1 - Safe - August 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Safer staffing

The table below summarises the average fill rate on each ward during August 2019. The fill rate is calculated by comparing planned staffing hours and actual staffing achieved.

In addition we are required to submit information on the total number of patients that were on each ward throughout the month – this is then used to calculate the "Care Hours per Patient Day" (CHPPD) metric. Our overall CHPPD for August was 7.95 care hours per patient per day.

	Aug-2019						
	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
Byland	80.3%	94.8%	89.0%	114.5%	2.37	3.18	5.55
Farndale	98.1%	86.0%	100.0%	103.2%	3.82	4.26	8.07
Granby	93.6%	120.2%	100.0%	109.7%	3.31	3.43	6.74
Harlow	103.2%	90.3%	100.0%	-	7.08	1.81	8.89
ITU/HDU	93.0%	-	98.1%	-	22.94	2.80	25.73
Jervaulx	85.1%	103.6%	94.2%	129.6%	2.62	3.68	6.30
Lascelles	96.7%	94.2%	98.4%	100.0%	4.06	3.64	7.71
Littondale	81.0%	99.5%	94.6%	125.8%	3.78	2.70	6.48
Maternity	88.9%	73.8%	95.2%	88.7%	14.34	3.73	18.07
Medical Assessment Unit	83.4%	100.5%	97.6%	101.6%	4.50	2.86	7.36
Medical Short Stay	94.3%	97.2%	100.0%	132.3%	4.40	2.95	7.35
Nidderdale	90.2%	102.2%	90.3%	174.2%	3.45	2.59	6.04
Oakdale	77.3%	91.5%	98.9%	108.6%	3.38	3.84	7.21
Special Care Baby Unit	94.4%	59.7%	96.8%	-	16.13	2.78	18.90
Trinity	96.7%	87.1%	100.0%	100.0%	3.86	4.05	7.91
Wensleydale	81.0%	110.5%	100.0%	106.5%	3.73	2.89	6.62
Woodlands	73.0%	67.7%	86.0%	61.3%	11.93	2.83	14.76
Trust Total	**87.4%**	**97.2%**	**96.2%**	**111.6%**	**4.72**	**3.23**	**7.95**

Harrogate and District NHS Foundation Trust

Section 1 - Safe - August 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Further information to support the August safer staffing data

On the wards: Byland, Jervaulx, MAU, Oakdale, Littondale and Wensleydale where the Registered Nurse (RN) fill rate was less than 100% against planned; this reflects current band 5 Registered Nurse vacancies and is reflective of the local and national position in particular regarding the difficulties in recruiting Registered Nurses. The Trust is engaged in an extensive recruitment plan in response to this.

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

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

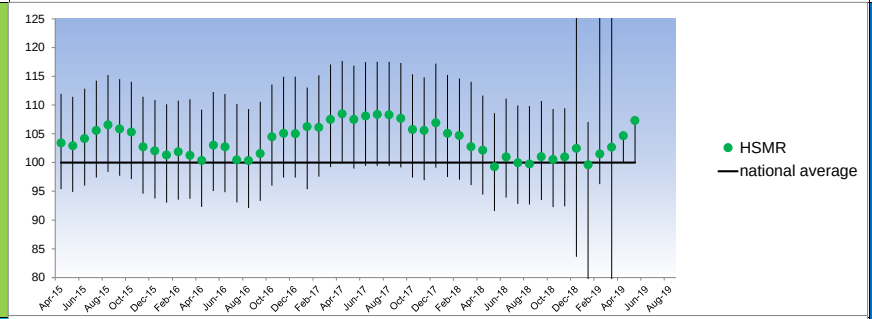
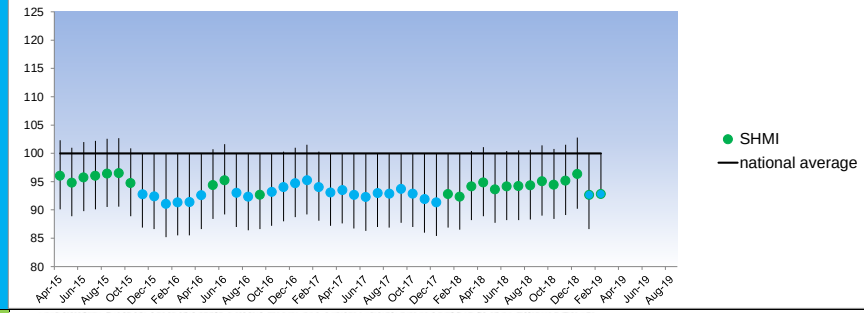
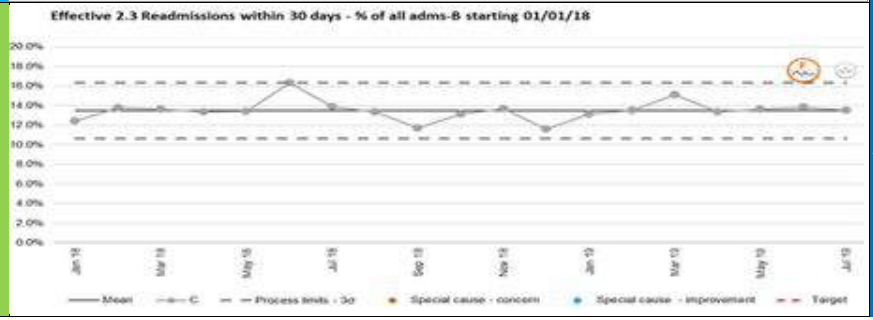
The planned staffing levels on the Delivery Suite and Pannal ward (maternity wards) have been combined to reflect the close working relationship of these two areas and the movement of staff between the wards in response to fluctuating occupancy and activity levels. Some of the Registered Midwife gaps were due to vacancy and sickness and the care staff gaps due to sickness in August; 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 August this is reflected on the wards; Byland, Jervaulx, MSS, Oakdale, Granby, Littondale, Farndale, Wensleydale and Nidderdale

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

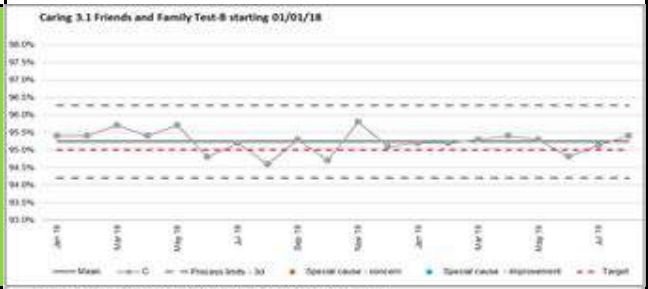
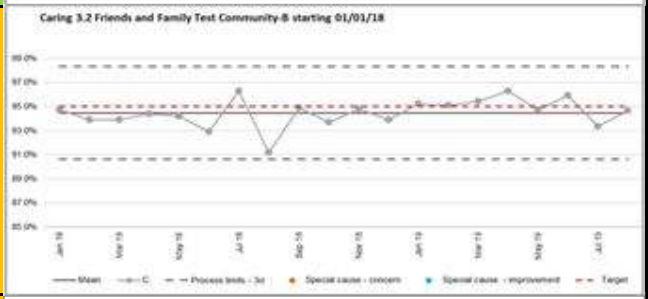
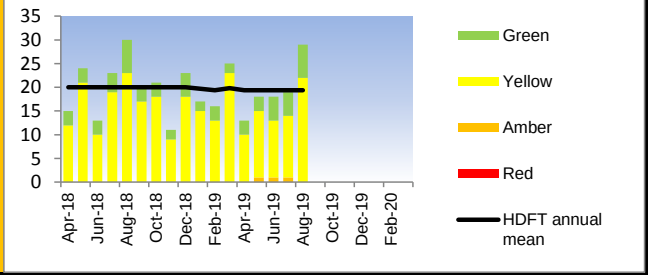
On Woodlands ward the day and night time RN and care staff hours are less than 100% in August, however the ward occupancy levels vary considerably which means that particularly in this area the number of planned and actual nurses is kept under constant review.

Section 2 - Effective - August 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
2.1	Mortality - HSMR DQ		Our HSMR has increased to 103.1 for the last 12 months up to March 2019 (100.68 the previous month). Three specialties have a higher than expected standardised mortality rate: Anaesthetics, Geriatric Medicine and General Medicine. The trust is performing above national average which is currently 99.2.
2.2	Mortality - SHMI DQ		SHMI data is now available on HED up to end of February 2019. HDFT's SHMI for the most recent rolling 12 months was 94.11. This remains below expected levels. No new SHMI data is currently available, so it is still currently sitting at 94.11 At specialty level, 5 specialties (Trauma and Orthopaedics, Gastroenterlogy, Respiratory Medicine, Geriatric Medicine, and General Medicine) have a standardised mortality rate above expected levels.
2.3	Readmissions DQ		Emergency Readmissions slightly decreased from 13.8% in July to 13.6% in August. This is roughly at the samel level as the 2018/19 average.

Harrogate and District NHS Foundation Trust

Section 3 - Caring - August 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
3.1	Friends & Family Test (FFT) - Patients DQ		95.4% of patients surveyed in August would recommend our services remaining above the latest published national average (93.6%). 4,659 patients responded to the survey this month of which 4,445 would recommend our services.
3.2	Friends & Family Test (FFT) - Adult community services DQ		94.6% of patients surveyed in August would recommend our services, an increase on last month (93.3). Current national data (March) shows 95% of patients surveyed would recommend the services. 372 patients from our community services responded to the survey this month of which 352 would recommend our services.
3.3	Complaints DQ		29 complaints were received in August which is 10 higher than July and above the average for 2018/19. None of the complaints were classified as amber or red this month. CCCC has now introduced a weekly tracker to monitor timeliness and stage of the complaints process.

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NHS Foundation Trust

Section 4 - Responsive - August 2019

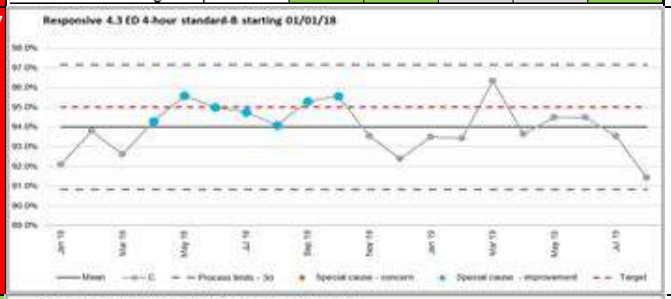
NHS Improvement Single Oversight Framework

4.1 NHS Improvement Single Oversight Framework — DQ

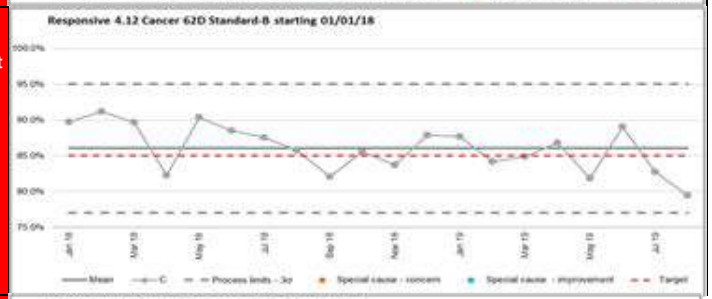
Standard	Q1	Q2	Q3	Q4	YTD
RTT incomplete pathways	88.5%	89.0%			88.6%
A&E 4-hour standard	94.2%	92.3%			93.4%
Cancer - 62 days	85.5%	81.9%			84.1%
Diagnostic waits	99.4%	99.2%			99.3%
Dementia screening - Step 1	93.4%	92.4%			93.0%
Dementia screening - Step 2	96.6%	85.0%			91.8%
Dementia screening - Step 3	100.0%	75.0%			92.0%

4.2 RTT Incomplete pathways performance — DQ

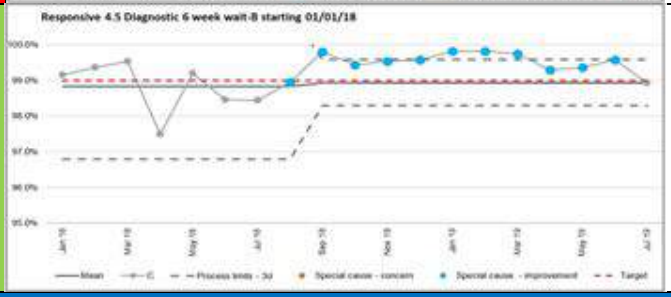
4.3 Cancer - 62 day wait for first treatment from urgent GP referral to treatment — DQ



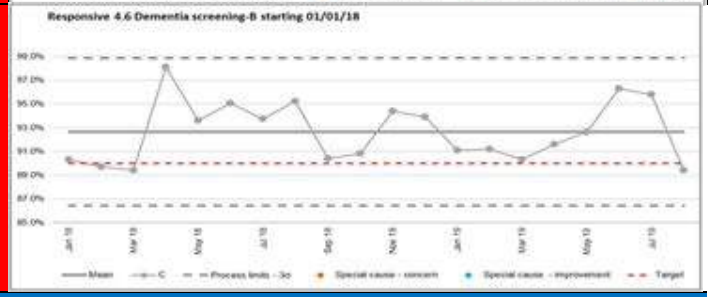
4.4 Cancer - 62 day wait for first treatment from urgent GP referral to treatment — DQ



4.5 Diagnostic waiting times - 6-week standard — DQ



4.6 Dementia screening — DQ



Narrative

Performance against the 62 day cancer standard was not delivered for August with provisional performance at 78.9% (see a more detailed summary below). As a result of the Trust's recovery plan, performance against the 2WW breast symptomatic standard has significantly improved in August to 70%, with performance expected to further improve in September.

The 62 day screening standard was also not delivered in August with provisional performance at 75%. We are currently expecting no further breaches for the quarter.

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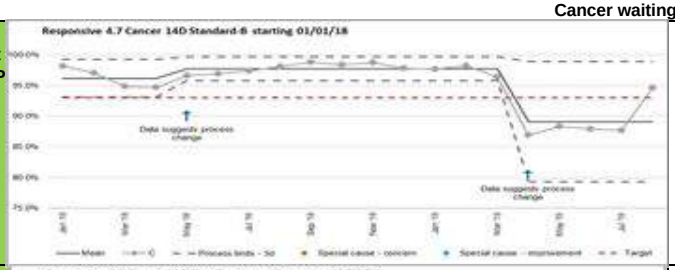
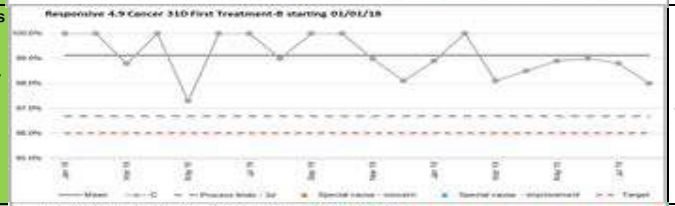
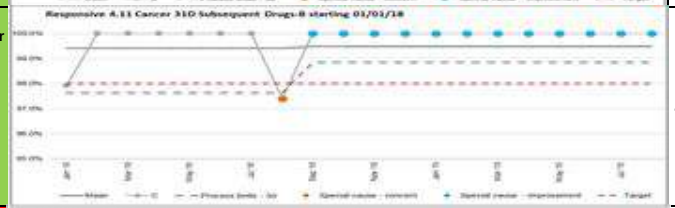
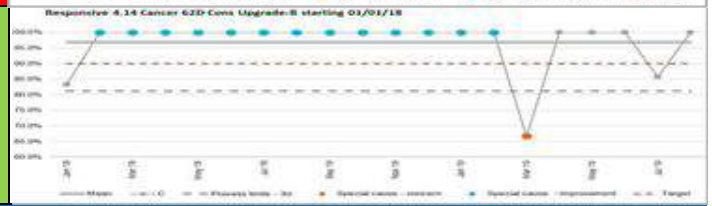
NHS Foundation Trust

Section 4 - Responsive - August 2019

Cancer waiting times standards

4.7	Cancer - 14 days max wait from urgent GP referral for suspected cancer	DQ		4.8	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	D	
4.9	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	DQ		4.10	Cancer - 31 day wait for second or subsequent treatment: Surgery	DQ	
4.11	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	DQ		4.12	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	DQ	
4.13	Cancer - 62 day wait for first treatment from screening service	DQ		4.14	Cancer - 62 day wait for first treatment from consultant upgrade	DQ	

Narrative

Provisional data indicates that 4 of the 8 cancer waiting times standards were achieved in August, with the 14 day breast symptom, the 62 day, 62 day Screening, and 31 day surgical subsequent treatment standards not delivered.

Provisional data report that there were 57.0 accountable 62 day standard treatments in the month with 12.0 breaches, meaning performance was below the standard at 78.9%. Of the 11 tumour sites, 5 had performance below 85% in August - Breast (2 breaches), Haematology (1 breach), Lower GI (2.5 breaches), Lung (1.0 breach), and Urological (5.0 breaches). 3 patients waited over 104 days for treatment in August - all breaches and near misses are scheduled to be reviewed at breach analysis in the last week of September.

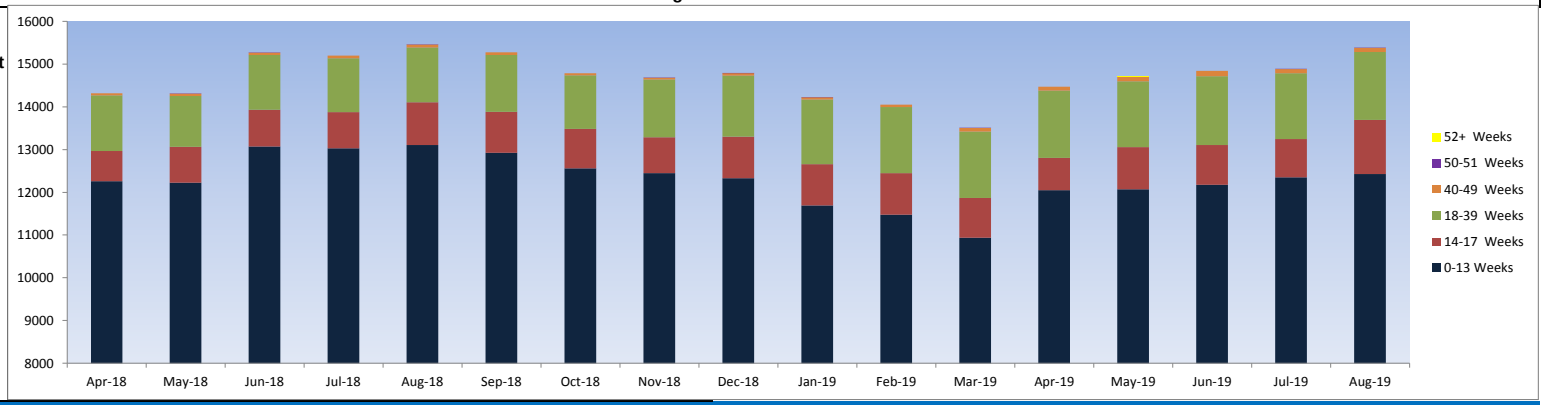
There were 60 non-cancer related breast symptomatic attendances in August, with 18 patients seen after day 14 (70.0%). The denominator for the 14 day suspected cancer standard was 822 in August with 44 patients first seen outside 14 days (94.6%), which is the first time the standard has been delivered since March 2019.

Harrogate and District NHS Foundation Trust

Section 4 - Responsive - August 2019

RTT waiting list metrics

4.15	RTT waiting list split by weeks	DQ



Narrative

There were a total of 15,387 patients on the RTT waiting list at the end of August; this is below our agreed trajectory of 15,852. There were no patients waiting over 52 weeks at the end of the month.

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NHS Foundation Trust

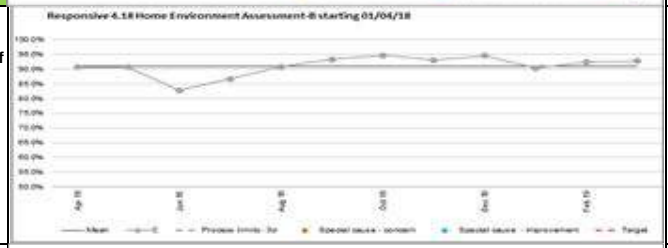
Section 4 - Responsive - August 2019

Children's Services metrics

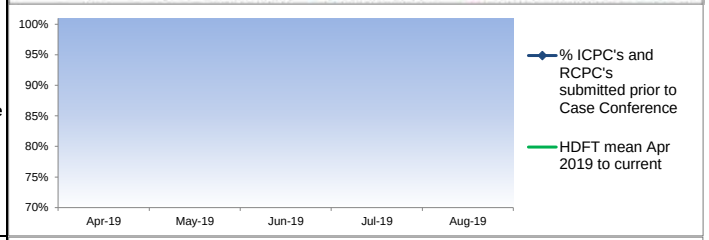
4.16 Children's Services - 10-14 day new birth visit — DQ

4.17 Children's Services - 2.5 year review — DQ

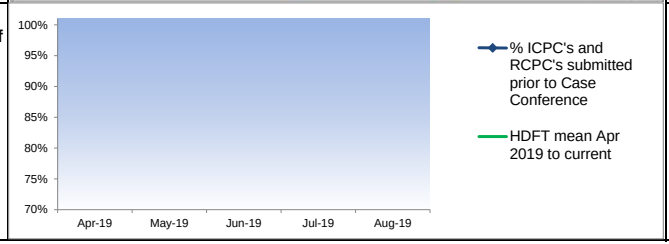
4.18 Children's Services - Use of the Home Environment Assessment Tool — DQ



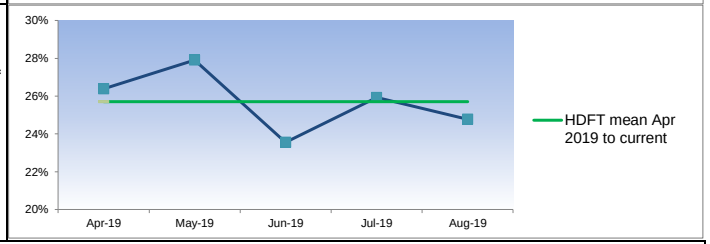
4.19 Children's Services - Reports for Initial and Review Child Protection Case Conferences — DQ



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

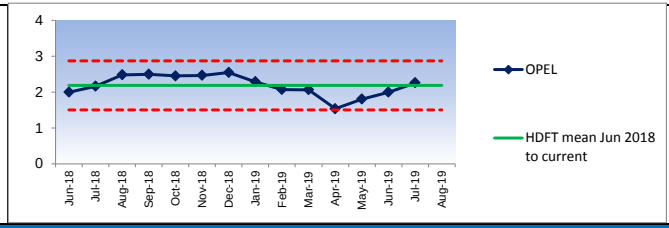


4.21 Children's Services - Reports for Achievement of KPI for Breast Feeding Prevalence. — DQ

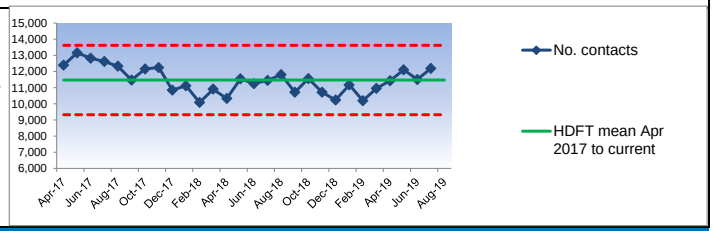


Adult Community Services metrics

4.22 OPEL level - Community Care Teams — DQ



4.23 Community Care Teams - patient contacts — DQ



Narrative

The Community Care Teams have now commenced mobilisation to form the new Harrogate and Rural Alliance community teams with partners in the Local Authority. The current metrics will therefore be reviewed to reflect the new ways of working and the integrated model of delivery.

NHS
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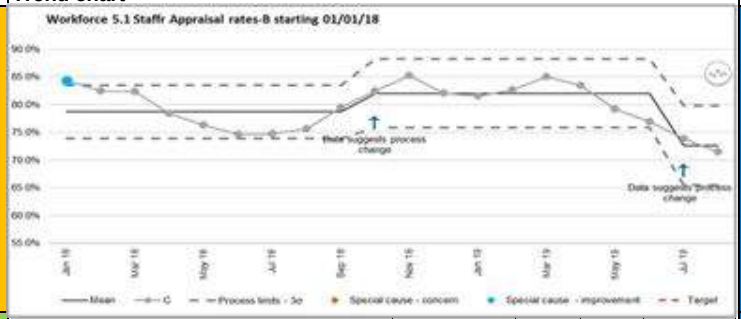
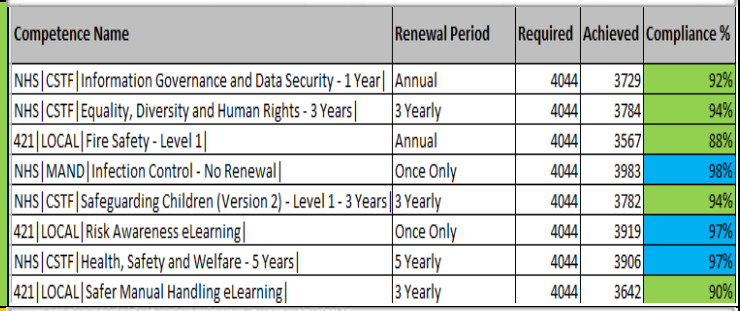
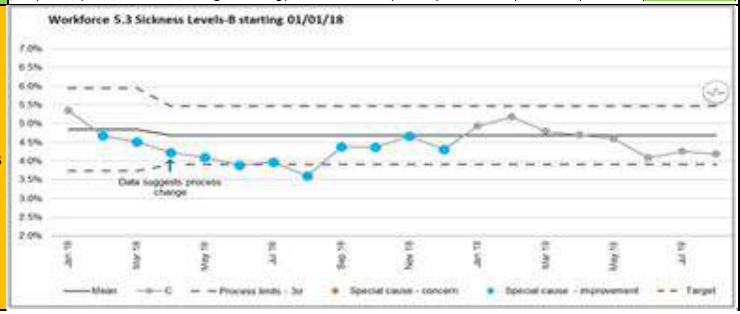
NHS Foundation Trust

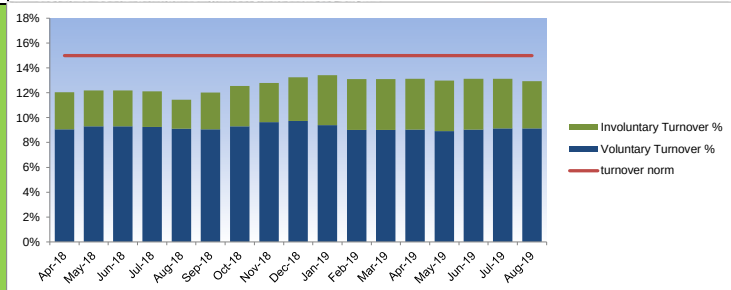
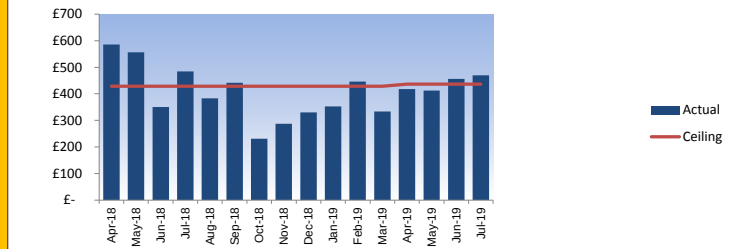
Section 5 - Workforce - July 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.1	Staff appraisal rates DQ		There continues to be a reduction in appraisal rates to 71.48% in August from 73.81% in July 2019 the Appraisal window closes on 30th September 2019, with the aim of ensuring 90% of staff are appraised during this period. A reminder will be sent out to remind managers to complete appraisals before the end of September. A full review of the appraisal window will be undertaken following its closure to understand its effectiveness.
5.2	Mandatory training rates DQ		Mandatory % Report – Trust exc HIF 01.08.19 The data shown is for the end of August and excludes the Harrogate Integrated Facilities (HIF) staff who transferred into the new organisation on the 1st March 2018. The overall training rate for mandatory elements for substantive staff is 94% which is just below the level of the last reporting cycle which was 95%.
5.3	Sickness rates DQ		The Trust sickness absence rate in August was 4.18% which is a decrease of 0.08% from Julys rate of 4.26% . Although this continues to remain above the Trust target of 3.9% it remains lower than the rates of absence in both April and May. HR are continuing to run a number of Absence Masterclasses to assist managers in proactively managing and supporting staff who are absent from work due to ill health. Departmental Risk Assessments are being carried out where a high level of absence due to stress and anxiety have been identified. The review of the Managing Attendance and Promoting Health and Wellbeing policy is ongoing.

Competence Name	Renewal Period	Required	Achieved	Compliance %
NHS|CSTF|Information Governance and Data Security - 1 Year|	Annual	4044	3729	92%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	3 Yearly	4044	3784	94%
421|LOCAL|Fire Safety - Level 1|	Annual	4044	3567	88%
NHS|MAND|Infection Control - No Renewal|	Once Only	4044	3983	98%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years	3 Yearly	4044	3782	94%
421|LOCAL|Risk Awareness eLearning|	Once Only	4044	3919	97%
NHS|CSTF|Health, Safety and Welfare - 5 Years|	5 Yearly	4044	3906	97%
421|LOCAL|Safer Manual Handling eLearning|	3 Yearly	4044	3642	90%

Harrogate and District NHS Foundation Trust

Section 5 - Workforce - July 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.4	Staff turnover rate DQ		Turnover for August has remained fairly static from July.
5.5	Agency spend in relation to pay spend DQ		Agency expenditure remains a concern despite the improvement in August.

Narrative

Sickness Absence

The Trust sickness absence rate in August was 4.18% which is a decrease of 0.08% from Julys rate of 4.26% . Although this continues to remain above the Trust target of 3.9% it remains lower than the rates of absence in both April and May. HR are continuing to run a number of Absence Masterclasses to assist managers in proactively managing and supporting staff who are absent from work due to ill health. Departmental Risk Assessments are being carried out where a high level of absence due to stress and anxiety have been identified. The review of the Managing Attendance and Promoting Health and Wellbeing policy is ongoing.

Turnover

Turnover for August has remained fairly static from July.

Appraisal Rate

There continues to be a reduction in appraisal rates to 71.48% in August from 73.81% in July 2019 the Appraisal window closes on 30th September 2019, with the aim of ensuring 90% of staff are appraised during this period. A reminder will be sent out to remind managers to complete appraisals before the end of September. A full review of the appraisal window will be undertaken following its closure to understand its effectiveness.

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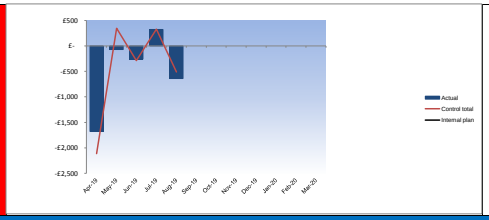
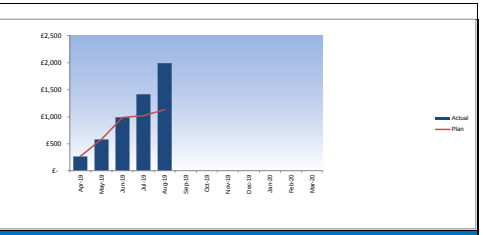
Harrogate and District
NHS Foundation Trust

Section 6 - Efficiency and Finance - August 2019

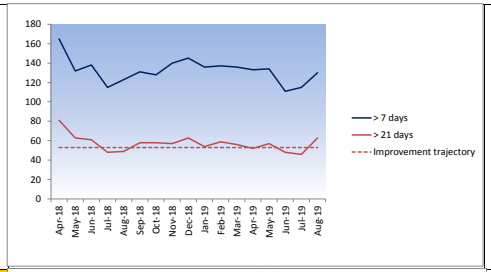
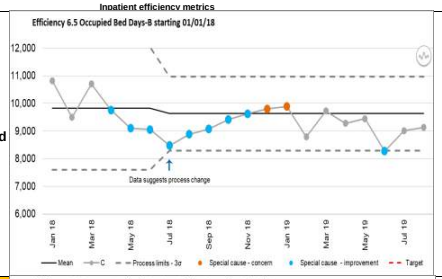
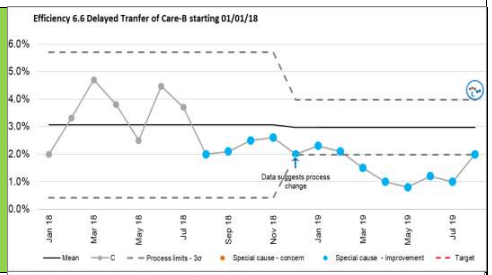
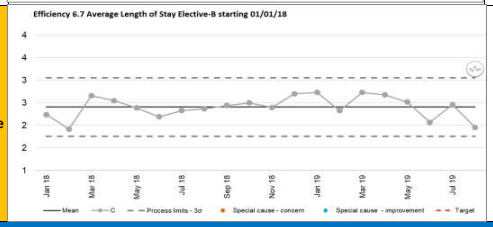
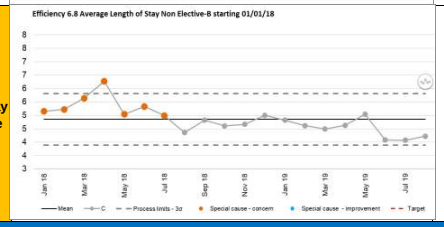
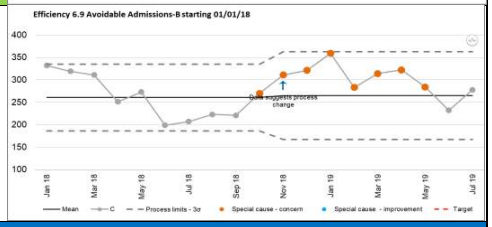
6.1	**Surplus / deficit and variance to plan**		6.2	**NHS Improvement Single Oversight Framework - Use of Resource Metric**	Finance		
					Element	Plan	Actual
					Capital Service Cover	4	4
					Liquidity	1	1
					I&E Margin	4	4
					I&E Variance From Plan		1
					Agency	1	1
					UoR Rating	3	3
6.3	**Capital spend**						

Narrative

The Trust reported a deficit position in August of £640k. This was £132k adverse to plan. In month variances are outlined on the following page. This deficit position increased the year to date deficit to £2,314k.

The Trust reported a UoR rating of 3 in August.

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

6.4	**Long stay patients**		6.5	**Occupied bed days**		6.6	**Delayed transfers of care**	
6.7	**Length of stay - elective**		6.8	**Length of stay - non-elective**		6.9	**Avoidable admissions**	

Narrative

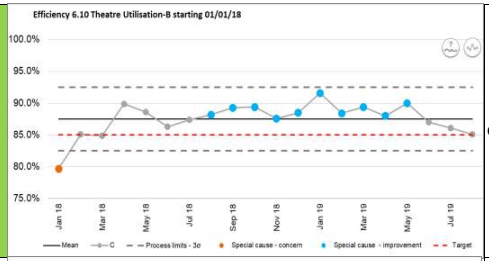
Non Elective Length of stay was above the national and benchmark group average in August at 4.22 days.

NHSI/E have written to the Trust setting a 42% improvement target for the number of patients in a hospital bed over 21 days. In order to monitor our progress against this target NHSI/E will require that each Trust establish a team, headed up by a senior manager, to undertake a weekly review of every patient in hospital more than 21 days. These will need to take place on the wards with the outcomes captured and coded and then submitted nationally. For HDFT this process needs to be in place by Sept 19 and we will need to adjust the board report to reflect the trajectory submitted.

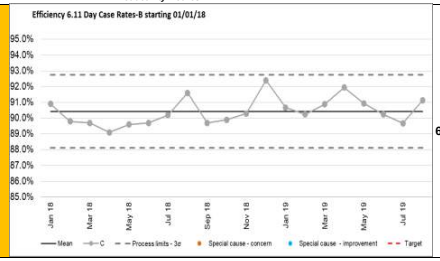
Section 6 - Efficiency and Finance - August 2019

Productivity metrics

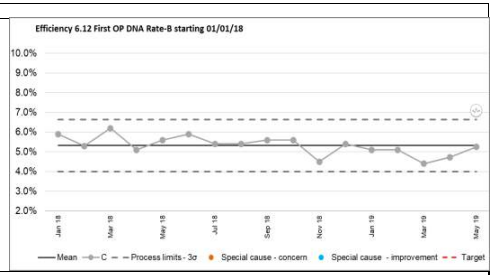
6.10 Theatre utilisation



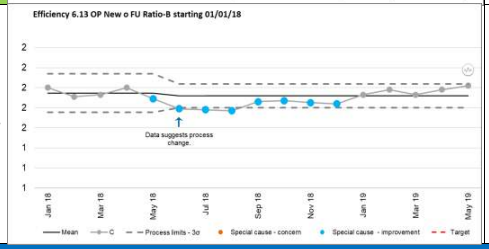
6.11 Day case rate



6.12 Outpatient DNA rate



6.13 Outpatient new to follow up ratio



Narrative

New to Follow-up ratio's increased slightly in May but is at a similar level to the HDFT mean from April 2016 to current and is lower than the benchmark group and national average. The planned care group have plans to continue to focus on this through different elements of the programme and therefore it is expected they will begin to fall again.

NHS
Harrogate and District
NHS Foundation Trust

Section 7 - Activity - August 2019

Narrative

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

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

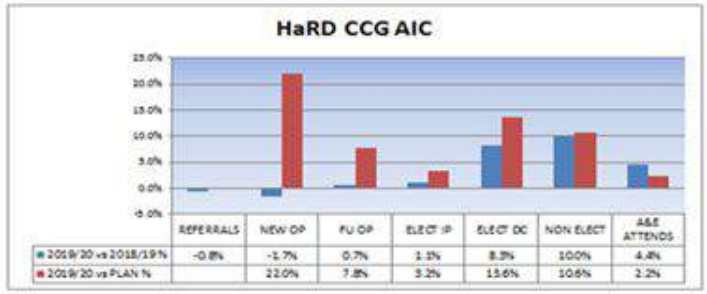
Discussions with Leeds CCG alongside LTHT have resulted in agreement transfer of patients back to HDFT from Leeds, and also to pursue a longer term solution that ensures the future flow of work from the Leeds area. This flow of work to HDFT is supported by LTHT and Leeds CCG, and actions are being take to work together to enable this to happen. There have now been 321 patients transferred to HDFT in September in Colorectal Surgery, Rheumatology, Dermatology and Urology and we would expect to see these convert to activity in the coming months.

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

Activity Summary

HaRD CCG AIC

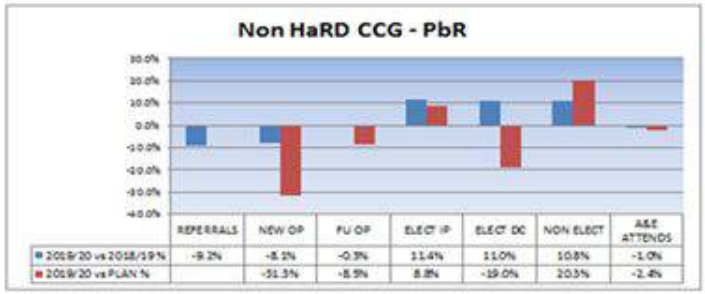
GROUP	2018/19 AUG	2019/20 AUG PLAN	2019/20 AUG ACTUAL	2018/19 YTD	2019/20 YTD PLAN	2019/20 YTD ACTUA	2019/20 vs 2018/19	2019/20 vs PLAN	2019/20 vs 2018/19 %	2019/20 vs PLAN %
REFERRALS	3085		3009	16150		16028	-122		-0.8%	
NEW OP	5,671	4,506	5,197	28,193	22,716	27,704	-489	4,988	-1.7%	22.0%
FU OP	10,725	10,149	10,215	54,786	51,181	55,157	371	3,976	0.7%	7.8%
ELECT IP	161	161	189	913	894	923	10	29	1.1%	3.2%
ELECT DC	1,777	1,541	1,767	8,406	8,009	9,100	694	1,091	8.3%	13.6%
NON ELECT	1,446	1,342	1,500	6,879	6,839	7,565	686	726	10.0%	10.6%
A&E ATTENDS	3,090	3,122	3,173	15,747	16,085	16,442	695	357	4.4%	2.2%



Non-HaRD CCG - PbR*

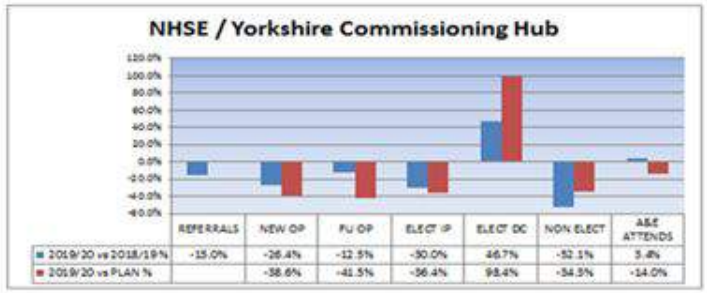
GROUP	2018/19 AUG	2019/20 AUG PLAN	2019/20 AUG ACTUAL	2018/19 YTD	2019/20 YTD PLAN	2019/20 YTD ACTUA	2019/20 vs 2018/19	2019/20 vs PLAN	2019/20 vs 2018/19 %	2019/20 vs PLAN %
REFERRALS	1,669		1,373	8,519		7,738	-781		-9.2%	
NEW OP	2,498	3,274	2,240	12,299	16,465	11,306	-993	-5,159	-8.1%	-31.3%
FU OP	3,942	4,350	3,666	20,118	21,915	20,059	-59	-1,856	-0.3%	-8.5%
ELECT IP	88	92	100	500	512	557	57	45	11.4%	8.8%
ELECT DC	696	869	768	3,375	4,623	3,745	370	-878	11.0%	-19.0%
NON ELECT	421	382	471	2,111	1,945	2,339	228	394	10.8%	20.3%
A&E ATTENDS	1,268	1,211	1,244	6,157	6,241	6,093	-64	-148	-1.0%	-2.4%

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



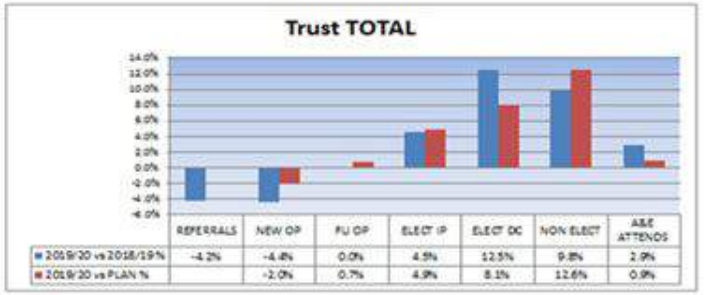
NHSE / Yorkshire Commissioning Hub

GROUP	2018/19 AUG	2019/20 AUG PLAN	2019/20 AUG ACTUAL	2018/19 YTD	2019/20 YTD PLAN	2019/20 YTD ACTUA	2019/20 vs 2018/19	2019/20 vs PLAN	2019/20 vs 2018/19 %	2019/20 vs PLAN %
REFERRALS	235		201	1,176		1,000	-176		-15.0%	
NEW OP	284	332	185	1,396	1,673	1,027	-369	-646	-26.4%	-38.6%
FU OP	357	766	420	2,584	3,864	2,260	-324	-1,604	-12.5%	-41.5%
ELECT IP	2	2	2	10	11	7	-3	-4	-30.0%	-36.4%
ELECT DC	266	75	202	1,211	895	1,776	565	881	46.7%	98.4%
NON ELECT	8	7	5	48	35	23	-25	-12	-52.1%	-34.3%
A&E ATTENDS	15	21	21	89	107	92	3	-15	3.4%	-14.0%



Trust Total

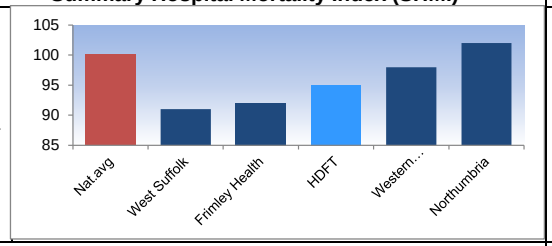
GROUP	2018/19 AUG	2019/20 AUG PLAN	2019/20 AUG ACTUAL	2018/19 YTD	2019/20 YTD PLAN	2019/20 YTD ACTUA	2019/20 vs 2018/19	2019/20 vs PLAN	2019/20 vs 2018/19 %	2019/20 vs PLAN %
REFERRALS	4,989		4,583	25,845		24,766	-1,079		-4.2%	
NEW OP	8,453	8,112	7,622	41,888	40,854	40,037	-1,851	-817	-4.4%	-2.0%
FU OP	15,024	15,265	14,301	77,488	76,960	77,476	-12	516	0.0%	0.7%
ELECT IP	251	255	291	1,423	1,417	1,487	64	70	4.5%	4.9%
ELECT DC	2,739	2,567	2,708	12,992	13,527	14,621	1,629	1,094	12.5%	8.1%
NON ELECT	1,875	1,731	1,976	9,038	8,819	9,927	889	1,108	9.8%	12.6%
A&E ATTENDS	4,373	4,354	4,438	21,993	22,433	22,627	634	194	2.9%	0.9%



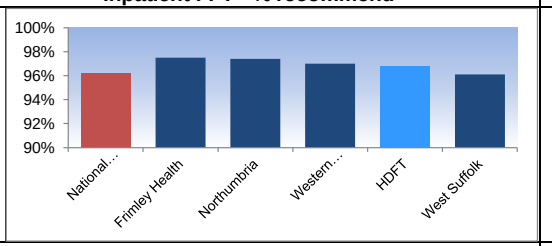
Harrogate and District NHS Foundation Trust

Section 8 - Benchmarking - August 2019

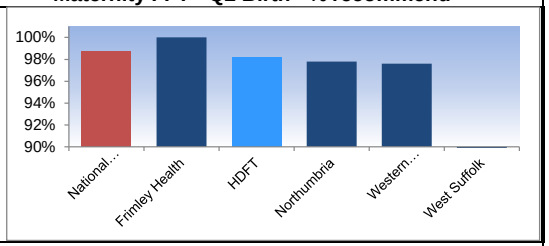
8.1 Summary Hospital Mortality Index (SHMI)



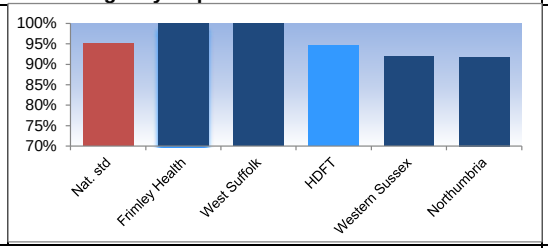
8.2 Inpatient FFT - % recommend



8.3 Maternity FFT - Q2 Birth - % recommend

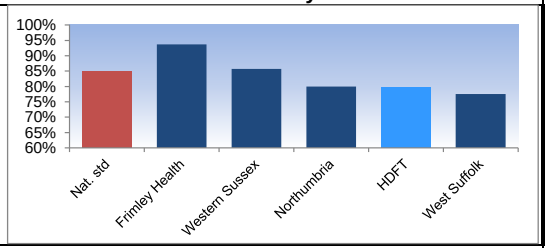


8.4 Emergency Department 4 hour standard

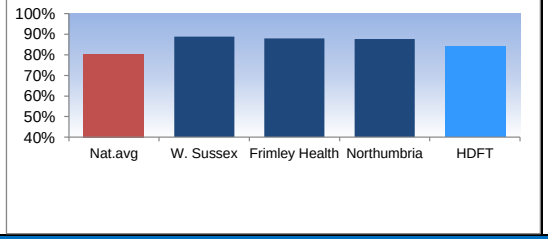


8.5 RTT incomplete pathways

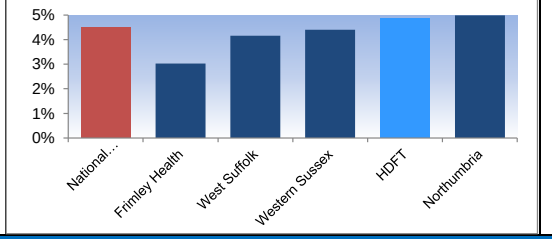
8.6 Cancer 62 days



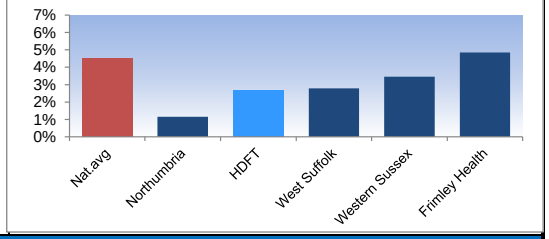
8.7 Staff FFT - % recommend (place to work)



8.8 Sickness absence



8.9 Proportion of temporary staff



Narrative

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

Harrogate and District NHS Foundation Trust

Integrated board report - August 2019

Key for SPC charts

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

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

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Data Quality - Exception Report

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

Indicator traffic light criteria

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Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
1.1	Safe	Pressure ulcers - hospital acquired	The chart shows the number of category 2, category 3, category 4 or unstageable hospital acquired pressure ulcers in 2018/19. The Trust has set a local trajectory for 2018/19 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes hospital teams only.	tbc	tbc
1.1	Safe	Pressure ulcers - hospital acquired	The chart shows the number of category 2, category 3, category 4, unstageable and DTI hospital acquired pressure ulcers, including device related and device related mucosal for 2019/20. The data includes hospital teams only.		
1.2	Safe	Pressure ulcers - community acquired	The chart shows the number of category 2, category 3, category 4 or unstageable community acquired pressure ulcers in 2018/19. This metric includes all pressure ulcers identified by community teams including pressure ulcers already present at the first point of contact. The Trust has set a local trajectory for 2018/19 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes community teams only.	tbc	tbc
1.2	Safe	Pressure ulcers - community acquired	The chart shows the number of category 2, category 3, category 4, unstageable and DTI community acquired pressure ulcers, including device related and device related mucosal for 2019/20. The data includes community teams only.		
1.3	Safe	Safety thermometer - harm free care	Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%.
1.4	Safe	Safety thermometer - harm free care - community care teams	As above but including data for community teams only.		
1.5	Safe	Falls	The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good.	Blue if YTD position is a reduction of >=50% of HDFT average for 2018/19, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2018/19, Amber if YTD position is a reduction of up to 20% of HDFT average for 2018/19, Red if YTD position is on or above HDFT average for 2018/19.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
1.6	Safe	Infection control	HDFT's C. difficile trajectory for 2019/20 is 19 cases, an increase of 8 on last year's trajectory. This increase takes into account the new case assignment definitions. Cases where a lapse in care has been deemed to have occurred would count towards this. Hospital apportioned MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2019/20. The last reported case of hospital acquired MRSA at HDFT was in Oct-12.	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, NHS Improvement and contractual requirement
1.7	Safe	Incidents - all	The number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
1.8	Safe	Incidents - comprehensive SIRIs and never events	The number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services. Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the presure ulcer / falls indicators above.	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
1.9	Safe	Safer staffing levels	Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is provided in the narrative section and published on the Trust website.	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
2.1	Effective	Mortality - HSMR	The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
2.2	Effective	Mortality - SHMI	The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.		
2.3	Effective	Readmissions	% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.	Blue if latest month rate < LCL, Green if latest month rate < HDFT average for 2018/19, Amber if latest month rate > HDFT average for 2018/19 but below UCL, red if latest month rate > UCL.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
3.1	Caring	Friends & Family Test (FFT) - Patients	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
3.2	Caring	Friends & Family Test (FFT) - Adult Community Services	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of adult community services including specialist nursing teams, community care teams, community podiatry and GP OOH. A high percentage is good.		

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Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
3.3	Caring	Complaints	The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.	Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2017/18, Amber if on or above HDFT average for 2017/18, Red if above UCL. In addition, Red if a new red rated complaint received in latest month.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
4.1	Responsive	NHS Improvement governance rating	NHS Improvement use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the right shows how the Trust is performing against the national performance standards in the "operational performance metrics" section. From 1st April 2018, dementia screening perfromance forms part of this assessment.	As per defined governance rating	
4.2	Responsive	RTT Incomplete pathways performance	Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks. A high percentage is good.	Green if latest month >=92%, Red if latest month <92%.	NHS England
4.3	Responsive	A&E 4 hour standard	Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%. The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good.	Blue if latest month >=97%, Green if >=95% but <97%, amber if >= 90% but <95%, red if <90%.	NHS England, NHS Improvement and contractual requirement of 95% and a locally agreed stretch target of 97%.
4.4	Responsive	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.5	Responsive	Diagnostic waiting times - 6-week standard	Percentage of patients waiting 6 weeks or less for a diagnostic test. The operational standard is 99%. A high percentage is good.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.6	Responsive	Dementia screening	The proportion of emergency admissions aged 75 or over who are screened for dementia within 72 hours of admission (Step 1). Of those screened positive, the proportion who went on to have an assessment and onward referral as required (Step 2 and 3). The operational standard is 90% for all 3 steps. A high percentage is good.	Green if latest month >=90% for Step 1, Step 2 and Step 3, Red if latest month <90% for any of Step 1, Step 2 or Step 3.	NHS England, NHS Improvement and contractual requirement
4.7	Responsive	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.8	Responsive	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.9	Responsive	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good.	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
4.10	Responsive	Cancer - 31 day wait for second or subsequent treatment: Surgery	Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good.	Green if latest month >=94%, Red if latest month <94%.	NHS England, NHS Improvement and contractual requirement
4.11	Responsive	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good.	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
4.12	Responsive	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.13	Responsive	Cancer - 62 day wait for first treatment from consultant screening service referral	Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good.	Green if latest month >=90%, Red if latest month <90%.	NHS England, NHS Improvement and contractual requirement
4.14	Responsive	Cancer - 62 day wait for first treatment from consultant upgrade	Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.15	Responsive	RTT waiting list split by weeks	Number of referred patients waiting for treatment broken down into weeks.	tbc	tbc
4.16	Responsive	Children's Services - 10-14 day new birth visit	The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good. Data shown is for North Yorkshire, Darlington, Co. Durham, Middlesbrough, Stockton, Gateshead and Sunderland. A high percentage is good.	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
4.17	Responsive	Children's Services - 2.5 year review	The percentage of children who had a 2.5 year review. A high percentage is good. Data shown is for North Yorkshire, Darlington, Co. Durham, Middlesbrough, Stockton, Gateshead and Sunderland. A high percentage is good.	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
4.18	Responsive	Children's Services - Use of the Home Environment Assessment Tool	The % of eligible children in Durham who had a HEAT assessment. The performance target is 95%.	Green if latest month >=95%, Amber if between 90% and 94%, Red if <90%.	Contractual requirement
4.19	Responsive	Children's Services - Reports for Initial and Review Child Protection Case Conferences	The % of reports submitted prior to Case Conferences (where reports are reqeusted earlier than 48 hours before Case Conference.)	Green if latest month >=95%, Red if <95%.	Contractual requirement
4.20	Responsive	Children's Services - staff compliance with Safeguarding Supervision.	% of community staff achieving 80% compliance for Safeguarding Supervision.	Green if latest month >=100%, Red if <100%.	Locally agreed metric
4.21	Responsive	Children's Services - % achievement against KPI for Breast Feeding Prevalence at 6-8 weeks.	% of children breast fed at the 6-8 week review. Charted against Prevalence targets for all 0-5 services.	Green if latest month >=100%, Amber if between 90% and 99%, Red if <90%.	Contractual requirement
4.22	Responsive	OPEL level - Community Care Teams	The OPEL (Operational Pressures Escalation Level) is a measure of operational pressure being experienced by the community care teams. A value of 1 to 4 is agreed each day, with 1 denoted the lowest level of operational pressure and 4 denoting the highest. The chart will show the average level reported by adult community services during the month.	tbc	Locally agreed metric
4.23	Responsive	Community Care Teams - patient contacts	The number of face to face patient contacts for the community care teams.	tbc	Locally agreed metric
5.1	Workforce	Staff appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good.	Annual rolling total - 90% green. Amber between 70% and 90%, red<70%.	Locally agreed target level based on historic local and NHS performance
5.2	Workforce	Mandatory training rate	Latest position on the % substantive staff trained for each mandatory training requirement	Blue if latest month >=95%; Green if latest month 75%-95% overall, amber if between 50% and 75%, red if below 50%.	Locally agreed target level - no national comparative information available until February 2016
5.3	Workforce	Staff sickness rate	Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%. A low percentage is good.	Green if <3.9% , amber if between 3.9% and regional average, Red if > regional average.	HDFT Employment Policy requirement. Rates compared at a regional level also

Harrogate and District NHS Foundation Trust

Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
5.4	Workforce	Staff turnover	The staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
5.5	Workforce	Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis as a percentage of total pay bill. The Trust aims to have less than 3% of the total pay bill on agency staff.	Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill.	Locally agreed targets.
6.1	Efficiency and Finance	Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.	Green if on plan, amber <1% behind plan, red >1% behind plan	Locally agreed targets.
6.2	Efficiency and Finance	NHS Improvement Financial Performance Assessment	From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this, Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4.	Green if rating =4 or 3 and in line with our planned rating, amber if rating = 3, 2 or 1 and not in line with our planned rating.	as defined by NHS Improvement
6.3	Efficiency and Finance	Capital spend	Cumulative Capital Expenditure by month (£'000s)	Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan	Locally agreed targets.
6.4	Efficiency and Finance	Long stay patients	This indicator shows the average number of patients that were in the hospital with a length of stay of over 7 days (previously defined as stranded patients by NHS Improvement) or over 21 days (previously super-stranded patients). The data excludes children, as per the NHS Improvement definition. A low number is good.	tbc	as defined by NHS Improvement
6.5	Efficiency and Finance	Occupied bed days	Total number of occupied bed days in the month.	tbc	Locally agreed targets.
6.6	Efficiency and Finance	Delayed transfers of care	The proportion of bed days lost due to being occupied by patients who are medically fit for discharge but are still in hospital. A low rate is preferable. The maximum threshold shown on the chart (3.5%) has been agreed with HARD CCG.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement
6.7	Efficiency and Finance	Length of stay - elective	Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
6.8	Efficiency and Finance	Length of stay - non-elective	Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		
6.9	Efficiency and Finance	Avoidable admissions	The number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.	tbc	tbc
6.10	Efficiency and Finance	Theatre utilisation	The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.
6.11	Efficiency and Finance	Day case rate	The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight. A higher day case rate is preferable.	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
6.12	Efficiency and Finance	Outpatient DNA rate	Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance. A low percentage is good. Patient DNAs will usually result in an unused clinic slot.		
6.13	Efficiency and Finance	Outpatient new to follow up ratio	The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.		
7.1	Activity	Outpatient activity against plan (new and follow up)	The position against plan for outpatient activity. The data includes all outpatient attendances - new and follow-up, consultant and non-consultant led.	Green if on or above plan in month, amber if below plan by < 3%, red if below plan by > 3%.	Locally agreed targets.
7.2	Activity	Elective activity against plan	The position against plan for elective activity. The data includes inpatient and day case elective admissions.		Locally agreed targets.
7.3	Activity	Non-elective activity against plan	The position against plan for non-elective activity (emergency admissions).		Locally agreed targets.
7.4	Activity	Emergency Department attendances against plan	The position against plan for A&E attendances at Harrogate Emergency Department. The data excludes planned follow-up attendances at A&E and pateints who are streamed to primary care.		Locally agreed targets.

Data quality assessment

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

Harrogate and District
NHS Foundation Trust

Financial Summary – Month 5

Board of Directors – 25th September 2019

Financial Position

Harrogate and District NHS Foundation Trust

The Trust reported a deficit position in August of £640k. This was £132k adverse to plan.

This deficit position increased the year to date deficit to £2,314k. While this appears behind plan, the impact of depreciation in relation to donated assets is deducted from the control total calculation, resulting in a position which is balanced against the control total.

The position includes the receipt of funding to support the pay award for Local Authority funded contracts. While it is positive the Trust has received this income, without this support the Trust would be behind plan.

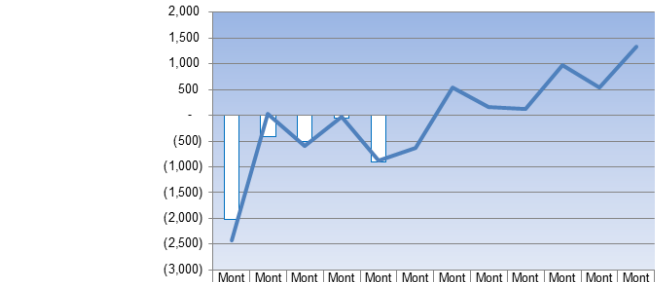
HDFT Monthly Financial Performance (£'000s)

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Actual	-1,677	-67	-256	326	-640							
Internal Plan	-2,111	349	-286	328	-508	-270	1,003	613	579	1,479	1,049	1,833

HDFT Cumulative Financial Performance (£'000s)

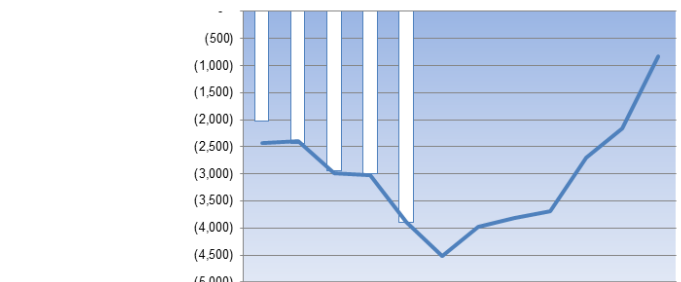
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Actual	-1,677	-1,744	-2,000	-1,674	-2,314							
Internal Plan	-2,111	-1,762	-2,048	-1,720	-2,228	-2,498	-1,495	-882	-303	1,176	2,225	4,058

HDFT Monthly Control Total Performance (£'000s)



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

HDFT Cumulative Control Total Performance (£'000s)



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

Key areas of risk

NHS Harrogate and District NHS Foundation Trust

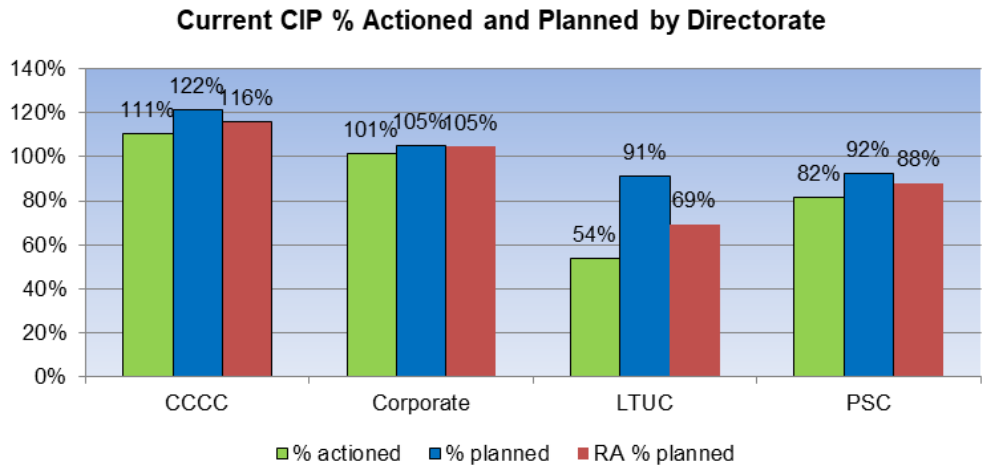
Issue	Comments	YTD Variance (£'000s)
Leeds Referrals and Activity	There is an ongoing adverse income variance as a result of changes to the referral process for planned care from the Leeds locality as well as casemix changes for unplanned care. Three potential solutions were previously described to the committee in relation to continued payment despite undertrading, addressing referral issue and/or reducing capacity. In relation to addressing the referral issue, discussions have been had with Leeds CCG alongside LTHT to agree transfer of patients back to HDFT from Leeds, and also to pursue a longer term solution that ensures the future flow of work from the Leeds area. This flow of work to HDFT is supported by LTHT and Leeds CCG, and actions are being take to work together to enable this to happen. The issue was also discussed with the ICS/Regulators and HaRD CCG at the last SOMB meeting. In terms of capacity, WLI capacity has been reviewed to manage down the cost whilst the activity flow is resolved. In terms of income, it has been agreed with Leeds CCG that the contract value for 2019/20 will be paid. We will continue to work with the Leeds system to resolve the activity flow and assist in managing the long waiters in Leeds, but the financial risk has been mitigated for this year. The variance of £791k reported to date will be adjusted in future months.	791
Delivery of HaRD transformation programme	The current assessed position following detailed review is that against a target of £2.0m, the current forecast is that £0.99m of efficiency improvement will be delivered. Unplanned care is forecast to manage £0.5m of pressures as planned, prescribing is forecast to deliver a further £0.15m (against a target of £0.5m) and planned care to deliver £0.34m (against a target of £1.0m). This is subject to ongoing work and scrutiny through the joint system governance arrangements.	-
Medical Staffing Expenditure Pressures	Complex issues in this area continue, with some progress made in relation to mitigations. Work undertaken through Directorates is currently forecast to improve the runrate by £280k by the year end across a number of specialties. In addition, plans currently discussed will reduce WLI will reduce expenditure by £300k to the end of the year.	577
Care Support Worker Vacancies	While this overspend continues, the first cohort recruitment event has been held with further events planned to ensure the pipeline of candidates is sufficient to meet operational needs and to contribute to reduced agency spend. Overall agency spend has reduced in August as compared to July.	196
CIP Delivery	CIP remains a key pressure across Planned and Surgical Care and Long Term and Unscheduled Care. Currently not developed to directorate level, there is also the further risk share agreed as part of the HaRD contract of £800k.	840
HIF	HIF has continued the trend from recent months of continuing to break even, with the deficit position remaining stable.	85
General Agency Expenditure Levels	Agency expenditure was marginally lower in August compared to previous months, however, it continues to remain close to the Agency Ceiling. It should be noted that the position to the right is the total agency variance to budget, however, some of this variance relates to the medical staffing pressures (£602k) and CSW Vacancies (£137k) above.	1,572
Non Pay	As outlined later in the report, there was a significant level of expenditure in August relating to Non Pay. Material elements of this relate to back dated pathology charges and Maternity recharges from Leeds Teaching Hospital. Alongside this has been a number of smaller variances which grouped together have a significant impact. Colleagues across the Trust have been reminded of the importance of controlling this area of spend more generally, as well as some actions in specific spend areas.	123

CIP Performance

Harrogate and District NHS Foundation Trust

Directorate Level CIP Performance is highlighted below –

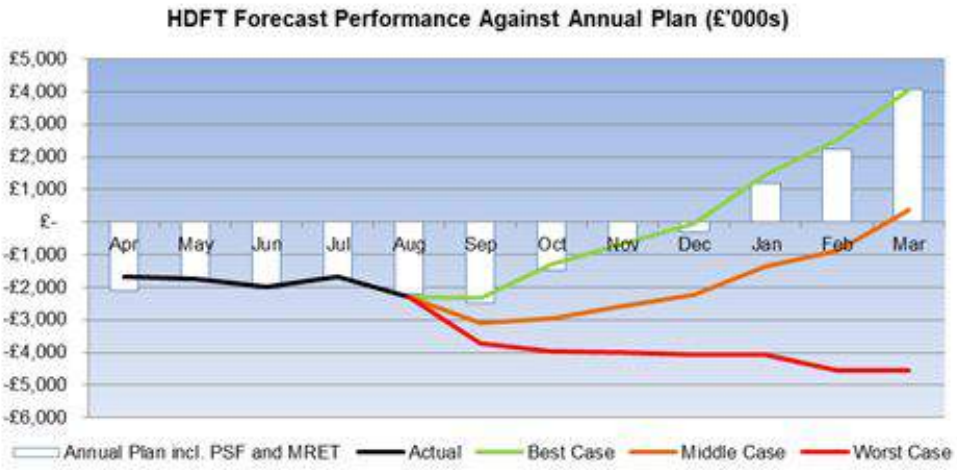
	CCCC	Corporate	LTUC	PSC	Total
Target	**1,700**	**2,206**	**2,255**	**2,245**	**8,406**
High	100	-	569	100	769
Medium	57	-	93	41	191
Low	30	79	183	100	392
Actioned	1,879	2,235	1,210	1,833	7,156
Total	**2,066**	**2,314**	**2,055**	**2,074**	**8,509**
RA Total	1,971	2,306	1,563	1,976	7,816



Forecast Outturn

Harrogate and District NHS Foundation Trust

The graphs below represent the anticipated forecast outturn for 2019/20.



As the table describes, the current forecast position is adverse to plan based on the current assumptions across the Trust.

Forecast directorate positions are described later in the document, with improved positions focused on PSC and LTUC.

The income forecast assumes no improvement in relation to the current income run rates for Leeds CCGs, or any income in association with the Risk Share arrangement with HaRD CCG. The improved income position will be adjusted in future months following positive discussions with Leeds CCG.

The best case scenario anticipates the risks outlined earlier in the report are mitigated to meet the current plan.

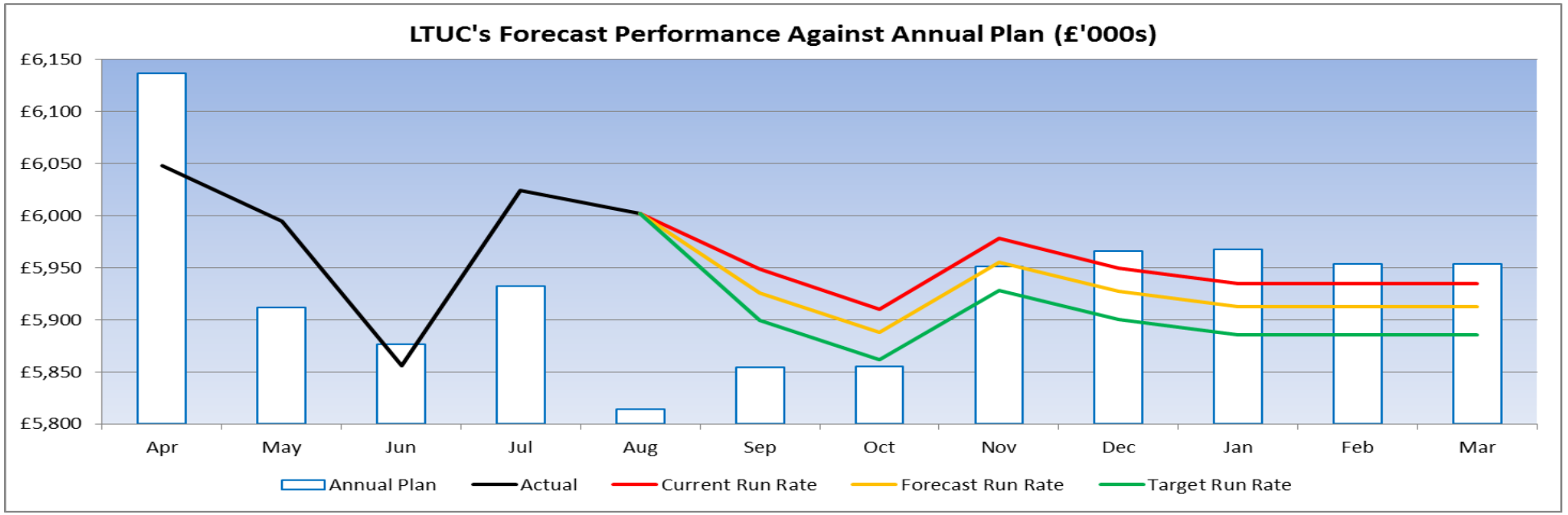
Pressure as a result of the UCI World Championships impact September performance in the middle and worst case scenarios, followed by differing degrees of pressure over winter and the continuation of the previously described pressures.

Each scenarios performance is then exaggerated by the associated impact of PSF funding.

Directorate forecast positions are highlighted below.

Area	Variance to plan (£'000s)
Commissioner Income	-2,126
LTUC	-740
PSC	-500
CCCC	827
Corporate	-110
Non Directorate Expenditure	
- CCG Risk share	-800
- Central	-423
- HIF Surplus	200
Current Forecast Variance	**-3,672**
Improved Directorate Performance	1,550
Improved Income Position	2,122
Remaining Risk	**0**

Executive Summary - LTUC



Annual Plan £71.17m (inc. £1.2m Winter Plan)

Current Run Rate £71.51m (£0.34m Gap to Plan)

Winter Plan costs not in run rate £400k

Operational Changes (£322k)

LTUC Actions (£142k)

Cancer Alliance (£150k)

Forecast Run Rate £71.36m (£0.19m Gap to Plan)

PSC – August 19 Expenditure Position

YTD Spend

£29.3m

August
Forecast
Excluding Action Plans
£70.4m

Current
Budget
Including Winter
Pressure Funding
£69.9m

Monthly Run rates	£m per month
Current	£5.86m
Forecast excluding action plans	£5.87m
Requirement September to March	£5.80m
Monthly Reduction Required versus *current*	£0.06m
Monthly Reduction Required versus forecast	£0.07m

ACTIONS TO PROGRESS

- WLI review - £300k
- Medical spend - £97k (high risk)
- Other areas being examined to close the financial gap

It should also be noted that income and expenditure related to Bowelscope needs to be aligned. This is likely to have a benefit to the position of at least £60k

Cashflow, Debtors and Creditors

Harrogate and District NHS Foundation Trust

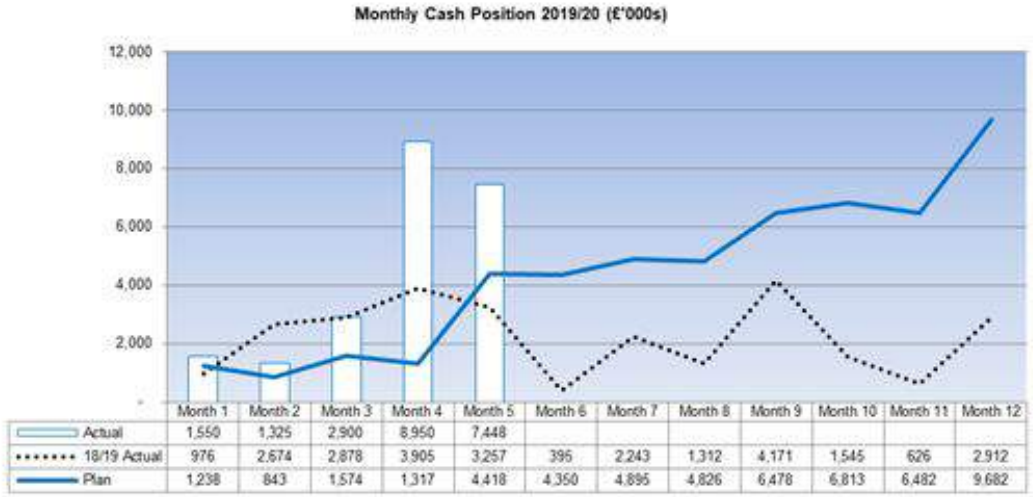
The Trust position continues to be more positive than in previous months.

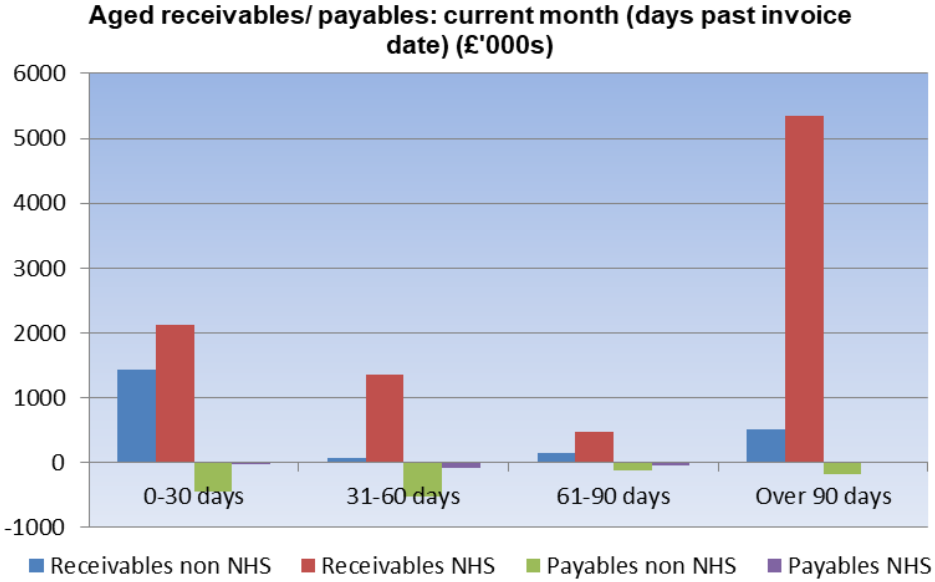
Overall, aged payables have reduced marginally since July. Positively the Trust has received payment for £1m of debts over 90 days.

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

Over the coming months the Trust will settle historic debts with NHS property services which will impact the cash position, likely bringing this back to planned levels.

Despite a number of risks still existing in relation to cash, there is a generally more positive position moving forward.





BPPC % of bills paid in target	Year to date		
	Current month	Previous month	Movement
Non NHS			
- By number	**6.5%**	**4.4%**	**2.1%**
- By value	**41.3%**	**5.0%**	**36.3%**
NHS			
- By number	**7.8%**	**7.2%**	**0.5%**
- By value	**39.3%**	**38.2%**	**1.1%**

Balance Sheet and Use of Resources

Harrogate and District NHS Foundation Trust

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

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

Statement of financial position summary	Current month			
	Plan £000s	Actual £000s	Variance £000s	%
Non-current assets	101,363	95,319	(6,044)	**(6.0%)**
Current assets	24,417	34,631	10,214	**41.8%**
Current liabilities - borrowings	(2,170)	(2,157)	13	**0.6%**
Current liabilities - other	(14,209)	(21,127)	(6,918)	**(48.7%)**
Total assets less current liabilities	**109,401**	**106,666**	**(2,735)**	**(2.5%)**
Non-current liabilities - borrowings	(16,164)	(16,164)	0	**0.0%**
Non-current liabilities - other	(152)	(139)	13	**8.6%**
Total net assets employed	**93,085**	**90,363**	**(2,722)**	**(2.9%)**

The Trust Use of Resources Risk Rating is outlined below.

Finance and use of resources rating	Expected Sign	03AUDITPY Audited PY 31/03/2019 Year ending Number	03PLANYTD Plan 31/08/2019 YTD Number	03ACTYTD Actual 31/08/2019 YTD Number	03VARYTD Variance 31/08/2019 YTD Number	03PLANCY Plan 31/03/2020 Year ending Number	03FOTCY Forecast 31/03/2020 Year ending Number
Capital service cover rating	+	1	4	4		2	2
Liquidity rating	+	1	1	1		1	1
I&E margin rating	+	1	4	4		1	1
I&E margin: distance from financial plan	+	1		1			1
Agency rating	+	1	1	1		1	1

Overall finance and use of resources risk rating	Expected Sign	03AUDITPY Audited PY 31/03/2019 Year ending Number	03PLANYTD Plan 31/08/2019 YTD Number	03ACTYTD Actual 31/08/2019 YTD Number	03VARYTD Variance 31/08/2019 YTD Number	03PLANCY Plan 31/03/2020 Year ending Number	03FOTCY Forecast 31/03/2020 Year ending Number
Overall rating unrounded	+	1		2.20			1.20
If unrounded score ends in 0.5	+	0		0.00			0.00
Risk ratings before overrides	+	1		2			1
Risk ratings overrides:							
Any ratings in table 6 with a score of 4 override - if any 4s "trigger" will show here	Text	No trigger		Trigger			No trigger
Any ratings in table 6 with a score of 4 override - maximum score override of 3 if any rating in table 6 scored as a 4	+	1		3			1
Control total override - Control total accepted	Text	Yes		Yes			Yes
Control total override - Planned or Forecast deficit	Text	No		No			No
Control total override - Maximum score (0 = N/A)	+	0		0			0
Is Trust under financial special measures	Text	No		No			No
Risk ratings after overrides	+	1		3			1

Harrogate and District NHS Foundation Trust

Date of Meeting:	25 September 2019	**Agenda item:**	**5.3**
Report to:	Board of Directors		
Title:	Operational Performance Report		
Sponsoring Director:	Mr Robert Harrison, Chief Operating Officer		
Author(s):	Mr Jonathan Green, Principal Information Analyst		

Report Purpose:

Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓

Executive Summary:

- Four of the eight cancer waiting times standards were achieved for Quarter 1, with the exception of the 14 day breast symptoms, 62 day, 62 day screening, and 31 day surgical subsequent treatments (monitored on a monthly basis).
- HDFT's performance against A&E 4-hour standard was 91.4% in August and year-to-date is at 93.4%. These are below the 95% standard.
- The Trust had no one waiting longer than 52 weeks on the RTT waiting list at the end of August. There were a total of 15,387 patients waiting on the list; this is below our agreed trajectory of 15,852.

Related Trust Objectives

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

Key implications

Risk Assessment:	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence;
Legal / regulatory:	Risk to segmentation based on the Single Oversight Framework
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None
Reference documents:	
Assurance:	

Action Required by the Board of Directors:

It is recommended that the Board:

- **Notes** items included in the report

8

You matter most

OPERATIONAL PERFORMANCE REPORT

1.0 SERVICE ACTIVITY

Following the reduction in referrals from Leeds, discussions with Leeds CCG alongside LTHT have resulted in agreement transfer of patients back to HDFT, and also to pursue a longer term solution that ensures the future flow of work from the Leeds area. This flow of work to HDFT is supported by LTHT and Leeds CCG, with agreement by all to work together to enable this to happen. We have seen a positive start to this piece of work with 321 patients transferred to HDFT in September and we would expect to see these convert to activity in the coming months.

At the end of August Non Elective Activity is 9.8% above the same time period last year, across all commissioners. This has meant that the hospital site has had to maintain escalation capacity beyond the plan for this year. Long stay patients (>21 days) have seen an increase in August which is a concern, work is ongoing to ensure we understand the reasons for this increase and actions required to further reduce. Further analysis has been carried out to understand the growth, which indicates a significant recent increase in General Surgery, Urology and Gastroenterology admissions, on top of the steady continuing rise in General Medical admissions. The growth is all through Emergency Department admissions.

Elective activity for the year-to-date is 11.7% higher than the same period last year with 58% of the additional activity originating from non-HaRD CCGs – there has been a 7.6% increase in HaRD elective activity (9,319 vs 10,023), and a 19.4% increase in non-HaRD elective activity (5,096 vs 6,085), although the latter remains below plan.

2.0 RTT PERFORMANCE

There were a total of 15,387 patients on the RTT waiting list at the end of August; this is below our agreed trajectory of 15,852 but is an increase of 498 from last month. This increase is partly due to the 321 patient transferred to HDFT from Leeds. There were no patients waiting over 52 weeks at the end of the month.

3.0 EMERGENCY DEPARTMENT PERFORMANCE

HDFT's Trust level performance against the 4-hour standard was 91.4% in August, below the required 95% standard, but above/below the trajectory of 93.8%. This includes data for the Emergency Department at Harrogate and Ripon MIU. The Trust is therefore currently below the required standard for Quarter 2 and the year-to-date with a Trust level performance of 92.3% and 93.4% respectively.

4.0 CANCER WAITING TIMES

Provisional data indicates that 4 of the 8 Cancer Waiting Times standards were achieved in August, with the standards for 14 day breast symptoms, 62 day, 62 day screening, and 31 day surgical subsequent treatment not delivered.

Provisional data report that there were 57.0 accountable 62 day standard treatments in the month with 12.0 breaches, meaning performance was below the standard at 78.9%. Of the 11 tumour sites, 5 had performance below 85% in August - Breast (2 breaches), Haematology (1 breach), Lower GI (2.5 breaches), Lung (1.0 breach), and Urological (5.0

breaches). 3 patients waited over 104 days for treatment in August - all breaches and near misses are scheduled to be reviewed at breach analysis in the last week of September.

There were 60 non-cancer related breast symptomatic attendances in August, with 18 patients seen after day 14 (70.0%) which is a significant improvement on recent months. As a result of the Trust's recovery plan performance is expected to further improve in September with the current forecast just below 93% (based on booked appointment at the time of writing).

The denominator for the 14 day suspected cancer standard was 822 in August with 44 patients first seen outside 14 days (94.6%), which is the first time the standard has been delivered since March 2019.

Harrogate and District NHS Foundation Trust

Date of Meeting:	**25 September 2019**	**Agenda item:**	**5.6**
Report to:	**Trust Board of Directors**		
Title:	Report by the Director of Workforce and Organisational Development		
Sponsoring Director:	Mrs Angela Wilkinson, Director of Workforce and Organisational Development		
Author(s):	Mrs Angela Wilkinson, Director of Workforce and Organisational Development		
Report Purpose:	**Decision** | **Discussion/ Consultation** ✓ | **Assurance** ✓ | **Information** ✓		
Executive Summary:	• **Recruitment of Non-Executive Directors up-date** • **Human Resources Policy Review Project** • **Listening Partners Programme Pilot Launched** • **First Line Leaders Programme Pilot Launched** • **Equality, Diversity and Inclusion Role** • **Pensions Consultation Up-date**		

Related Trust Objectives

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

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

Action Required by the Board of Directors:

The Board of Directors is requested to:

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

11

Harrogate and District NHS Foundation Trust

1. Sickness Absence

The Trust sickness absence rate in August was 4.18% which is a decrease of 0.08% from July's rate of 4.26%. Although this continues to remain above the Trust target of 3.9% it remains lower than the rates of absence in both April and May. HR are continuing to run a number of Absence Masterclasses to assist managers in proactively managing and supporting staff who are absent from work due to ill health. Departmental Risk Assessments are being carried out where a high level of absence due to stress and anxiety have been identified. The review of the Managing Attendance and Promoting Health and Wellbeing policy is ongoing.

2. Retention

Turnover for August has remained fairly static at 12.93% with a slight reduction from July's figure of 13.13%.

3. Appraisal Rate

There continues to be a reduction in appraisal rates to 71.48% in August from 73.81% in July 2019. The Appraisal window closes on 30th September 2019, with the aim of ensuring 90% of staff are appraised during this period. A reminder will be sent out to remind managers to complete appraisals before the end of September. A full review of the appraisal window will be undertaken following its closure to understand its effectiveness.

4. Recruitment of Non-Executive Directors

The recruitment plan is underway on behalf of the Council of Governors to replace Mrs Webster (31 December) and Mr Thompson (29 February) as Non-Executive Directors of the Trust. The Remuneration, Nomination and Conduct Committee of the Council appointed Gatenby Sanderson as the recruitment partner to support the process. The Committee agreed a timetable as follows;

- 27 August – Advert closed
- 4 September – Longlisting took place and 13 candidates were selected at this stage. Gatenby Sanderson is in the process of conducting the preliminary interviews with these candidates.
- 30 September – Shortlisting meeting. Following shortlisting, the selected candidates will be given the opportunity to visit the Trust before the final interview day
- 14 October selection process which includes a discussion with a focus group and a formal interview with the Committee.
- 6 November – Council of Governors will consider the preferred candidates

5. Human Resources Policy Review Project

The Human Resources (HR) team are commencing a review of Key HR policies to include, Managing Attendance, Promoting Health and Wellbeing and Disciplinary and Grievance policies. This project forms part of improving our people practices work.

The first steering group has now taken place and the first workshop to commence the review process, is due to take place on 11 October. Twenty-eight colleagues from multiple professions, including our Trade Union partners, are invited to this, have volunteered to be part of this work as broad staff representation is essential to ensure co-production of our approach. The Policy Review will take into account the recommendations of an independent review from Imperial London NHS Trust relating to the management and oversight of local investigating and disciplinary processes. All trusts were advised by Dido Harding (NHSi) to review their processes against seven criteria - which form part of this review into our policy. One of the key elements related to Board level oversight requiring mechanisms to be established so that data relating to investigation and disciplinary procedures is collated, recorded and regularly and openly reported at board. HDFT currently complies with this via our reporting through the Confidential Matters paper to the Board.

6. Listening Partners Pilot Programme

Our Listening Partners Programme pilot was launched during September, with four Executive Directors and seventeen colleagues (who are participating in our Royal College of Nursing (RCN) Clinical Leadership Programme) taking part. The programme is being run in partnership with the Yorkshire & the Humber NHS Leadership Academy. The programme is based around the concept of reverse mentoring, where HDFT are mentored by colleagues working at all levels across the Trust. The benefits of reverse mentoring are: increased diversity of thought influencing decision making, improved communications and new networks and surfacing of ideas for improvements in quality of care pathways. The governance arrangements include supervision for mentors and mentees and the programme being regularly reviewed by the Workforce & Organisational Development Steering Committee. Following evaluation of the pilot the programme will be rolled out more widely across the Trust.

7. First Line Leader Pilot Programme

Research provides direct links to NHS workers having a positive experience of working life to improved quality of patient care, and how people are led is fundamental to this. Therefore, in what has been a busy month, our three-day First Line Leader Programme pilot was also launched during September.

Two pilot groups have been established, each with 24 colleagues participating. The programme is designed to support our leaders by further developing their people management skills and creating a working environment where inclusive, compassionate and kind leadership is the norm, enabling colleagues to thrive in their roles and work environment.

Following evaluation of the two pilots, this programme will be rolled out across the Trust, with the ambition that the majority of those in a leadership role will have participated over a two year period. The programme is to be embedded into Induction programmes for newly appointed leaders.

8. Equality and Diversity

A Trustwide Equality, Diversity and Inclusion (EDI) lead role has been re-established within the Trust and the successful post holder has been appointed (Angie Colvin). The

successful 'Talk to me' launch is the beginning of a new focus on EDI across the Trust and the role is integrated within the Workforce and OD Directorate in order that there is alignment in the EDI work programme with OD, staff experience and HR practice development and transformation work.

9. Pensions Consultation

There are increasing reports nationally that NHS employees, (particularly higher-earning employees such as Consultants), are turning down additional work, requesting to reduce their working hours and retiring early due to concerns about taxation of pension contributions. This is having a significant impact on workforce supply, staff retention and service delivery nationally across NHS.

A review of this issue at HDFT by our Pensions Working Group has created twelve potential options for mitigating any staffing issues this may cause, and both expert legal advice and the Government's own guidance is incorporated into our planning. We are working positively and constructively with the Consultants Forum in order to mitigate the impact as far as possible at HDFT.

Additionally, NHS Employers is consulting further with stakeholders regarding pension scheme flexibilities and will update their guidance as a result. This consultation closes on 1 November 2019.

The Pensions Working Group will await the results of the consultation and the NHS Employers' final guidance and then finalise their recommendations.

A Wilkinson
Director of Workforce and Organisational Development
September 2019

Harrogate and District NHS
NHS Foundation Trust

Board Committee report to the Board of Directors

Committee Name:	Quality Committee (QC)
Committee Chair:	Laura Robson NED
Date of last meeting:	4th September 2019
Date of Board meeting for which this report is prepared	25th September 2019

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

Hot Spots:
There were no immediate concerns raised by members of the committee.

Complaints response times were discussed as a priority. The committee were informed of the recent work undertaken to support the RPIW which was to happen the following week. It was anticipated that the systematic review of the process would identify ways in which the response times would be improved. The committee will receive feedback at the October meeting.

Board Request for QC to seek assurance:
No recent requests have been received.
The committee is still awaiting assurance and resolution regarding the alternative to ReSPECT. A progress report due at the meeting has been deferred to October.

Reports Received:
Quality improvement project.
A presentation was received from Pamela Bagot, Principal Physiotherapist regarding her Silver Quality of Care Champion QI Project. Pamela had implemented a new system for managing out patient referrals which had both improved staff and patient experience. Waiting times had reduced, systems for tracking patients had improved and staff morale greatly improved as the result of clearer processes to follow. As a consequence of the discussion the COO was able to suggest further improvements that may be possible. The example demonstrated how improvement methodology and time to reflect can improve patient and staff experience and result in more efficient use of resources.

Quarterly Directorate Governance report
This month the report was from LTUC. A very visual and useful report which gave a comprehensive assessment of the Directorate. The committee were assured of the work underway to bring about improvements where required and to share good practise where appropriate.

Quarterly reports

- **Quarter 1 Patient experience report.** The report focusses on feedback from patients. This includes complaints monitoring, compliments, electronic feedback, etc. All issues identified were being addressed by the operational management teams.
- **Quarter 1 Patient Safety report.** The report provides assurance regarding Duty of Candour which demonstrates clear compliance. The recent improvement to DATIX has now been fully implemented. The report highlighted an increase in reported incidents to 2030 from 1871 in Quarter 4. 92% were low harm and 8% moderate or above. The report also highlighted poor compliance with the closure of CAS alerts, the CQC had identified the Trust as an outlier. This is being addressed by the team and will be monitored by the committee. The management of documents on the internet remains of concern with a number of them still out of date. The internet is not a satisfactory document management system and an alternative is required.
- **National Maternity and Perinatal Audit.** This report continues to identify the issues regarding maternity service provision that the Board has been previously appraised of. These are:
- Lack of a midwifery led unit therefore failure to provide a comprehensive choice for women.
- Requirement for an electronic maternity system.
- Implementation of continuity of midwifery carer for women. These items form part of the department's action plans. Other items from the audit show good compliance.
- **Clinical Audit report.** The report provides assurance regarding the work being undertaken to audit a wide range of issues within clinical services. The only risk identified was failure to complete projects registered with the audit team. These are frequently individual audits which are overly ambitious and cannot be completed within the proposed timescales. The committee was informed that they do not present a significant risk to the Trust.
- **NICE Compliance Report** The report provides assurance that the Trust is compliant with NICE guidance. In Quarter 4 NICE issued 58 pieces of guidance. Currently 18 responses are outstanding and they have been highlighted to directorates for action. Any risks due to non-compliance are highlighted on the directorate risk registers.
- **SEPSIS Progress report** The report details the actions being taken to improve SEPSIS screening across the Trust. There has been a significant improvement on Woodlands ward since a new admissions document had been implemented. Improvements in the electronic monitoring and continuous monitoring at ward level are the main actions required to improve screening. Despite the concerns about screening service delivery and treatment remains good and mortality rates are as expected.

- **Update from safety visits.** The committee received assurance from a number of safety visits undertaken. These visits are well received by staff and provide opportunity for a wide ranging discussion on patient safety issues. No new risks have been identified.

Quality Priorities

The committee received a report on progress implementing the quality priority to embed new reporting processes and the culture of learning from events, complaints and deaths.

The committee also received a very positive report on the progress against the quality priority to promote equality and reduce inequalities in access to services and information for staff and patients.

Both reports are available on diligent if board members wish to consider them.

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

Complaints response.

Delay implementing an agreed alternative to ReSPECT

Matters for decision

No decisions required

Action Required by Board of Directors:

To note.

12

Harrogate and District NHS Foundation Trust

Date of Meeting:	25 September 2019	**Agenda item:**	6.1
Report to:	Board of Directors		
Title:	Learning from deaths report Q1 2019/20		
Sponsoring Director:	Dr David Scullion, Medical Director		
Author(s):	Dr Sylvia Wood, Deputy Director of Governance		
Report Purpose:	**Decision**	**Discussion/ Consultation** ✓	**Assurance** ✓ **Information** ✓
Executive Summary:	During Q1 2019/20 eleven structured judgement reviews (SJRs) were completed with one case referred for a second review. The SJRs included eight cases that related to a SHMI alert associated with pathological fractures. 91% (10/11) patients reviewed had good or excellent overall care. The review of cases with pathological fracture identified that only 1/8 patients coded as having a pathological fracture actually had a cancer-related fracture. 7/8 patients could have been coded as osteoporotic hip/vertebral/acetabular fracture. Some problem in care was identified in two of the cases although neither resulted in harm. There was one death of a patient with learning disabilities that underwent a SJR during Q1. This is the case that was referred for a second review and was also referred to the national Learning Disabilities Mortality Review (LeDeR) programme. In general the structured judgement reviews contained numerous detailed descriptions of good practice. The report also includes: • Results of case note reviews of in-hospital cardiac arrests and an update about work related to DNACPR discussions. • Information from the 2017-18 LeDeR report. • Findings from an HDFT learning disability DNACPR audit. • Information about reviewing stillbirths and neonatal deaths, maternal deaths. The report is discussed at the Improving Patient Safety Steering Group and End of Life Operational Group to agree any actions, with themes and learning shared across the organisation using the #ChatterMatters newsletter.		

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

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

Action Required by the Board of Directors:

It is recommended that the Board:

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

Harrogate and District NHS Foundation Trust

Introduction

For those patient deaths meeting the criteria for a detailed review of case notes, the Medical Director appoints a clinician with appropriate expertise to undertake a structured judgement review (SJR). 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.

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.

All structured case note reviews undertaken during Q1 2019/20 have been included in this report. A subset of the structured case notes undertaken in this quarter were as a result of a summary hospital-level mortality indicator (SHMI) alert received by HDFT in April 2019 for patients with a pathological fracture. This showed that nine patients were coded as dying following pathological fracture from December 2017 to November 2018 which was an unexpectedly high number. The Medical Director commissioned a review of these cases.

All hospital cardiac arrests are reported to the National Cardiac Arrest Audit (NCAA) to monitor and report on the incidence of, and outcome from, in-hospital cardiac arrest in order to foster improvements in the prevention, care delivery and outcomes from cardiac arrest. It is a joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre) and is included in the Department of Health Quality Accounts. Further learning is sought by case notes reviews of all in-hospital cardiac arrests which are reviewed by the Resuscitation Committee to identify any areas of learning to share and determine whether the resuscitation is deemed appropriate or inappropriate; this information is also included in this report.

The report includes information about the LeDeR Programme, the results published in the 2017/18 annual LeDeR report and the local learning disabilities DNACPR audit.

Information has been also added to this report about the processes relevant to learning from stillbirths and neonatal deaths, as well as reviewing and investigating maternal deaths.

Results

Structured case reviews

Summary of inpatient deaths and structured case note reviews

		Quarter or year in which the death occurred															
					2017/18					2018/19					2019/20		
		2014/15	2015/16	2016/17	Q1	Q2	Q3	Q4	2017/18	Q1	Q2	Q3	Q4	2018/19	Q1	2019/20	
	No of inpatient deaths				145	140	167	205	657	142	140	177	182	641	177	177	
																	Total undertaken
Number of structured judgement reviews (SJRs)	**SJRs previously reported**	4	27	40	3	8	14	6	31	N/a	N/a	N/a	N/a	N/a	N/a	N/a	102
	Total SJRs undertaken during 2018/19 by year of death								31					29	N/a	N/a	60
	Total SJRs undertaken during Q1 2019/20 by year and Q of death										2	3	4	9	2	11	11
	Total number of SJRs undertaken relating to deaths in the period	**4**	**27**	**40**					**62**	10	14	8	6	**38**	**2**		**173**

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

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

Summary of review of patients coded as dying after pathological fracture

Dr Rebecca Leigh and Dr Angela Bell reviewed the case records or available information for the nine patients coded as dying following pathological fracture from December 2017 to November 2018. Eight case notes were reviewed with one set missing in archive. The RCP National Mortality Case Record Review structured judgement method was used to evaluate the notes and the findings were entered onto the Elderly Care mortality spreadsheet and the Datix database where possible. In some cases where the patient died outside hospital there was insufficient information to complete the SJR on Datix.

The review identified that 1/8 patients was coded as having a cancer-related fracture, and 7/8 patients were coded as having an osteoporotic fracture. Whilst it is common to think that pathological fracture refers to cancer-related fractures, with fractures related to osteoporosis being called osteoporotic or fragility fractures, a pathological fracture is defined as a fracture through bone which is affected by an underlying disease, usually neoplasm (cancer) or osteoporosis. Therefore all cases were correctly coded; the quality of care was good or excellent in all. Whilst 2 patients died

after discharge from hospital and the reasons are not known, the deaths of 6/8 patients were expected.

Assessment of care

The table below shows the assessment of care for the identified stages of care provision for each of the ten case reviews completed during Q1. 90% (5/5) patients reviewed had good or excellent overall care. The care is rated for each of up to seven phases or elements of care. Out of 70 possible phases or elements of care, 17 were not applicable, and 50/53 (94%) were rated as good or excellent.

Concerns about care were identified in one case reviewed by the Medical Director, and a second review was requested. The second review was undertaken by Dr Claire Taylor and the overall care rated as 4 (good). The difference of opinion was reviewed. The patient's case notes were not clear as to when the patient was seen by senior staff due to poor record keeping, but as Dr Taylor was familiar with the clinical staff involved and their seniority, she concluded that the care the patient received was good. Clinical record keeping standards were assessed overall as average; the documentation of doctors' grades and discipline should have been clearer, and documentation of the discussion with family should have been clearer and more thorough. It was agreed that Dr Taylor's conclusion was plausible and these would be the findings reflected in this report.

Care scores summary 2019/20 Q1

	Good or excellent care (score 4-5)	Average care (score 3)	Poor care (score 1-2)	N/a	Total
Admission and initial management	11	0	0	0	11
On-going care	9	1	0	1	11
Care during procedure	2	0	0	9	11
Peri-operative care	2	0	0	9	11
End of life care	10	0	1	0	11
Overall assessment of care received	10	1	0	0	11
Overall assessment of patient record	10	1	0	0	11

The poor care identified for one case regarding end of life care related to certification of the death following the decision to stop resuscitation. The cardiac arrest protocol was followed but there were delays in certification of death.

Problems with care

The SJR proforma has a section that enables the identification of problems in care. No problems in care were identified in 9/11 cases in Q1. Two cases were identified as having problems in care although neither case resulted in any harm.

Problems with care: 2019/20 Q1

	Degree of harm if problems identified			**Total**
	No harm	**Uncertain harm**	**Harm**	
No problems with care identified				9
Problems in care identified	2	0	0	2
Total				11

Deaths of patients with learning disabilities

There was one death of a patient with learning disabilities that underwent a SJR during Q1. This is the case that was referred for a second review and was also referred to the national Learning Disabilities Mortality Review (LeDeR) programme. As above, it was concluded that whilst there were issues with documentation in the case notes, the care received by the patient was good.

Results of case notes reviews of in-hospital cardiac arrests

This report includes the cardiac arrest case note reviews for Q1 as well as historical data for reference.

	2017/18						2018/2019					TOTAL
	Q1	Q2	Q3	Q4	**2017/18 Total**		Q1	Q2	Q3	Q4	**2018/19 Total**	
No of inpatient cardiac arrests	8	11	16	9	**44**		12	7	17	13	**49**	93
No of case note reviews	8	11	16	9	**44**		12	7	17	13	**49**	93
No of appropriate cardiac arrests	4	3	13	4	**24**		10	3	12	6	**31**	55
No of inappropriate cardiac arrests	4	8	3	5	**20**		2	4	5	7	**18**	38

	2019/20				
	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	**2019/20 Total**
No of inpatient cardiac arrests	17				
No of case note reviews	17				
No of appropriate cardiac arrests	9				
No of inappropriate cardiac arrests	8				

The cardiac arrest case note reviews show that the care provided prior to and during resuscitation calls is of a high standard, following national guidelines and hospital policy. However the Resuscitation Committee deemed 47% of Q1 resuscitation attempts as inappropriate. The reasons are detailed below for Q1:

Patient had a DNACPR decision in place but not known of or not found	Resuscitation stopped quickly due to futility therefore DNACPR should have been considered pre arrest	Patient had life limiting illness so a DNACPR should have been considered	DNACPR put in place post arrest therefore should have been considered prior to arrest
1	3	0	4

There is a variation in the reasons to deem resuscitation inappropriate. For the last two years the most prevalent reason has been “patient had life limiting illness so a DNACPR should have been considered”. However this quarter the majority of inappropriate resuscitations has been due to the fact that following successful resuscitation it was decided not to continue to actively treat a patient and a DNACPR decision was then made, therefore it is recommended that these decisions are considered during ward rounds or as prompted by changes in clinical conditions.

Work is underway with the WebV team to identify how we can utilise the electronic patient records system to help prompt these discussions. This is also the focus of the Appropriate Resuscitation and Escalation Operational (AERO) Group to help clinicians to identify which patients they should be having these discussions with and to provide an easy to use platform to document this on and communicate with the MDT in the trust and across community specialties. Work on this has been slow to get going and is due to be discussed at SMT to garner support and decide the direction the trust would like to take. Once there is agreement on an appropriate tool to use to guide discussions and documentation, work can progress to provide education on this and a RPIW is planned to improve the culture and willingness to start and document discussions and decisions regarding treatment escalation and resuscitation.

Results of LeDeR reviews

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

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

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

If there are any opportunities for learning identified during an initial review, the LeDeR programme will call a multiagency review. 1 multiagency review has been held during 2018/19 regarding a patient that died following an inpatient episode at HDFT. Elements of learning that were identified for HDFT were:

- Good practice – HDFT funding support from the patient's external carers.
- Good practice – Arranging for the patient to be visited by a pony on the ward
- Additional learning – Consider appointing an IMCA when contact with family is infrequent.
- Additional learning – Consider support and transport arrangements on discharge.

The 2017/18 annual LeDeR report available from http://www.bristol.ac.uk/sps/leder/ defines 12 key recommendations including the following:

- The Department of Health and Social Care, working with a range of agencies and the Royal Colleges to issue guidance for doctors that 'learning disabilities' should never be an acceptable rationale for a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, or to be described as the underlying or only cause of death on Part I of the Medical Certificate Cause of Death.
- Medical Examiners to be asked to raise and discuss with clinicians any instances of unconscious bias they or families identify e.g. in recording 'learning disabilities' as the rationale for DNACPR orders or where it is described as the cause of death.

Ben Haywood, HDFT Acute Liaison Nurse for Learning Disabilities and MCA has developed a helpful summary of the findings of the Learning Disabilities Mortality Review Programme.

Summary of the findings of the Learni

Learning disabilities and DNACPR audit

As a result of the findings published in the LeDeR annual report, Ben Haywood-Noble, Acute Liaison Nurse for Learning Disabilities and MCA has undertaken a LD/DNACPR audit. The audit included:

- All patients with an LD flag whose casenotes were in medical records library
- All patients with an LD flag who had died and their notes sent to archive.

The initial results indicate a number of inappropriately documented DNACPR decisions that are currently active.

Whilst the importance of this relates to ensuring appropriate clinical decisions are made, it is worth noting that DNACPR forms will be included in all future LeDeR reviews, and LeDeR has recommended that CQC include this in their inspections. On challenging inappropriately documented DNACPRs in the past, the decision-making has always been sound, therefore the risk is likely to be reputational.

Some actions have already been taken:

- DNCAPR is included in LD training (both face to face and e-learning);
- A poster has been developed for all wards and department to share learning from the LeDeR report (including DNACPR);
- Ben Haywood-Noble is compiling a one page summary of the LeDeR annual report to be communicated to all medical staff by Directorates;
- LD level 2 training is essential training for band 6 + nurses and AHPs. Any medical staff are welcome to attend and this will be highlighted on the one page summary.

Further actions need to be taken to ensure 'learning disabilities' including autism are never an acceptable rationale for a DNACPR order, and that any unconscious bias identified in recording 'learning disabilities' as the rationale for DNACPR orders or the cause of death is raised with individual clinicians.

Learning from stillbirths and neonatal deaths

All fetal and newborn deaths are reported through the Datix system under subcategories depending upon gestation and timing of the death (Intrauterine death <24 weeks, Stillbirth ≥24 weeks, Intrapartum Stillbirth, Neonatal Death).

All Datix incidents are reviewed initially through a weekly multidisciplinary Professional Advisory Panel (PAP) meeting in order to systematically review the case and identify any lapses in care.

All fetal deaths over 22^{+0} weeks of gestation and neonatal deaths up to 28 days postnatal (born at 20 weeks gestation of pregnancy or over) are notified to MBRRACE-UK via the online portal by the specialist Bereavement Midwife or Risk Management Midwife.

This will generate a notification for review through an objective online Perinatal Mortality Review Tool (PMRT), accessed through the MBRRACE-UK portal. The PMRT has been introduced to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. In particular it has been designed to review the care of the following babies:

- All late fetal losses (22^{+0} to 23^{+6})
- All antepartum and intrapartum stillbirths
- All neonatal deaths from birth at 22^{+0} to 28 days after birth
- All post-neonatal deaths where the baby is born alive from 22^{+0} but dies after 28 days following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

Review of these deaths is undertaken through a multidisciplinary panel in accordance with the PMRT guidance document within the Maternity Unit. Contribution is invited from the parents as part of the process. Following the review, a PMRT investigation report is generated together with an action plan, which can be used to support follow up debrief appointments with the parents.

Intrapartum stillbirths at Term (≥37 weeks of pregnancy) and early neonatal deaths (within the first 7 days) are also notified under the Royal College of Obstetricians & Gynaecologists Each Baby Counts programme through the online portal. Anonymised investigation reports are uploaded to the portal following completion, for independent peer review and to enable shared learning and national monitoring of themes.

These cases of intrapartum stillbirth and early neonatal death will also be notified to the Healthcare Safety Investigation Branch (HSIB) for external investigation in accordance with their criteria and investigation process. Notification is made through the secure MIDAS (Maternity Investigation Database and Support System) portal. Investigation findings are shared with the Trust and parents together with recommendations, and reviewed at CORM.

All neonatal and child deaths are also subject to notification to North Yorkshire Safeguarding Children Board (NYSCB) & City of York Safeguarding Children Board (CYSCB) for review by the Child Death Overview Panel (CDOP) as described above.

Any fetal loss, antenatal or intrapartum still birth or neonatal death may still be subject to the normal internal investigation process as defined in the Events and Serious Incident Policy as appropriate.

Reviewing and investigating maternal deaths

Maternal deaths are investigated as defined in the Maternal Death Guideline. The Trust reports to MBRRACE-UK for the National Confidential Enquiry into Maternal Deaths. See www.mbrrace.ox.ac.uk. Notification of Maternal Death will also be undertaken to HSIB for external investigation of Direct or Indirect maternal deaths in the perinatal period (within 42 days of the end of pregnancy.

The existence of these policies, guidelines and processes for infant or child deaths, stillbirths and maternal deaths does not exclude a structured case note review in selected cases where concerns are raised. This will usually be at the discretion of the Chief Nurse and/or Medical Director.

Reflection and learning identified

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

Responding to alerts from SHMI enables a focused review of cases to seek opportunities to learn and improve. The review of patients coded as dying after pathological fracture showed that all cases were correctly coded, the quality of care was good or excellent in all, and whilst 2 patients died after discharge from hospital and the reasons are not known, the deaths of 6/8 patients were expected.

The specific learning points identified during this process in Q1 2019/20 include recommendations to:

- Clarify the coding rules to see if clinicians can help coders more accurately code pathological fractures. It should be noted that this might result in increased numbers of coded pathological fractures.
- Improve oncology documentation and sharing of palliative care advance plans with the hospital.
- Address delays with death certification and documentation following unsuccessful resuscitation.
- Promote the need to gain collateral information and ascertain relatives' difficulties with home circumstances quicker.
- Improve completion of DNACPR forms in relation to patients with learning disabilities, clarifing that 'learning disabilities' including autism are never an acceptable rationale for a DNACPR order, acknowledging and addressing any unconscious bias.
- Promote clear documentation in medical records of roles and designation of clinical staff, and dates and times of entries.

This summary has been across the organisation using #ChatterMatters newsletter;

Summary of the findings of the Learning Disabilities Mortality Review Programme

In June 2019 the Learning Disabilities mortality Review (LeDeR) Programme published it's third annual report. The LeDeR programme is funded by NHS England and was established in response to the Confidential Inquiry into the premature deaths of people with learning disabilities (CIPOLD).

The LeDeR programme is notified of all deaths of patients known to have learning disabilities. For each death there is an initial review. If there are any areas of concern in relation to the care of the person who has died a multiagency review will be undertaken. The purpose of the multiagency review is to identify any potentially avoidable contributory factors, note any best practice, agree whether the person's death at that time was potentially avoidable, make any necessary recommendations and agree a provisional action plan.

Key Findings

Age at death - The median age at death for people with learning disabilities was 59 years. For males it was 60 years; for females 59 years. This data suggests a disparity in the age at death for people with learning disabilities and the general population to be 23 years for males and 27 years for females.

Place of death - The proportion of people with learning disabilities dying in hospital was 62%; in the general population it is 46%.

Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) - Reviewers felt that the majority (79%) of DNACPR orders were appropriate, and correctly completed and followed. However, 3% of these reviews reported that the term 'learning disabilities' or 'Down's syndrome' was given as the rationale for the DNACPR order.

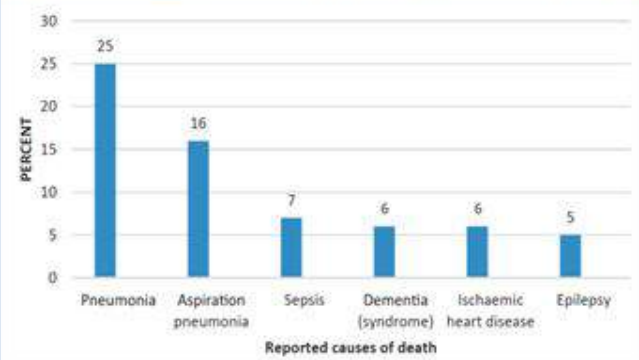
16% of deaths are ascribed to 'congenital malformations and chromosomal abnormalities' most commonly Down's syndrome. 15 deaths of people with learning disabilities were coded with an underlying cause of death as being *'Developmental disorder of scholastic skills, unspecified'*, a commonly used code for 'learning disabilities'.

Three of the recommendations made in the annual report relate specifically to the documentation of DNACPR orders and death certificates.

- The Department of Health and Social Care, to issue guidance for doctors that 'learning disabilities' should never be the rationale for a DNACPR order, or to be described as the cause of death.
- Medical Examiners to raise with clinicians any instances of unconscious bias e.g. in recording 'learning disabilities' as the rationale for DNACPR orders or where it is described as the cause of death.
- The Care Quality Commission to be asked to identify and review DNACPR orders and Treatment Escalation Personal Plans relating to people with learning disabilities at inspection visits.

A recent HDFT audit has highlighted that inappropriate terms such as 'Down's syndrome', 'learning disabilities' and 'autism' were present in 35% of all DNACPR orders relating to patients with learning disabilities. These should never be documented on a DNACPR form as part of the rationale to not resuscitate.

Figure 13: The six most common conditions mentioned on Part I of the MCCD[37] of people with learning disabilities for whom a verified ICD-10 code has been provided



Causes of death

Pneumonia was more frequently the cause of death in people with severe or profound and multiple learning disabilities (28%) compared to people with mild/ moderate learning disabilities (22%). This was often related to poor oral hygiene.

The second most frequently reported condition was aspiration pneumonia (16% of all deaths). The report recommends that all patients admitted with recurrent chest infections are reviewed by Speech and Language Therapy

Deaths from sepsis accounted for 7% of deaths overall.

Deaths from dementia accounted for 6% of deaths overall. As might be expected, dementia was strongly associated with age.

Ischaemic heart disease was reported in 6% of all deaths. As in the general population it was significantly associated with age (8% of deaths aged 65 and over, compared with no deaths before the age of 25)

Epilepsy was the sixth most frequently cited cause of death (5% of all deaths). People with severe and profound or multiple learning disabilities died from epilepsy more frequently (8%) than those with mild or moderate learning disabilities.

13

Quality of care

At the end of their review, having considered all of the evidence available to them, reviewers are requested to provide an overall assessment of the quality of care provided to the person

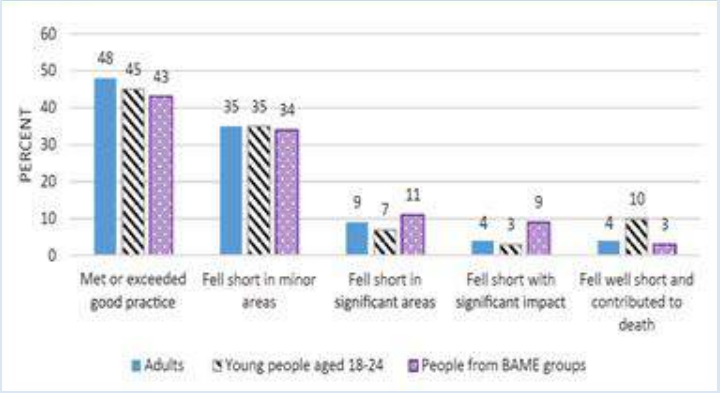
Almost half (48%) of deaths reviewed in 2018 received care that the reviewer felt met or exceeded good practice.

The reasons for falling short of good practice varied, but included problems with care that were related to:

- Clinical care.
- Medication and equipment.
- Not summoning medical attention in a timely way.
- A lack of coordination of a person's care and treatment.

Seventy-one adults with learning disabilities (8%) were reported to have received care that fell so far short of expected good practice that it significantly impacted on their well-being or directly contributed to their cause of death. Each of these deaths would receive further investigation and/or multi-agency review.

Figure 15: Reviewer assessment of the quality of care provided to people with learning disabilities



Multiagency Reviews

Multi-agency review panels reviewed 112 deaths, reflecting on a series of questions about any contributory factors to the death that may have been potentially avoidable.

Potentially avoidable contributory factors - Potentially avoidable contributory factors to a death were considered in relation to the person's care (e.g. the quality of pain relief, nutritional support, provision of reasonable adjustments) and the way services were organised and accessed (e.g. assessment processes).

Those relating to the person's care were identified in 45% of deaths, and in relation to the way services were organised and accessed in 49%.

Delays in care or treatment

108 reviews (12%) noted that delays had been apparent. The delays described are various:

- Identifying that a person was unwell.
- Appropriate investigations being carried out and treatment started.
- The availability of assessments.
- Discharge from hospital.
- Delayed recognition of approaching end of life - affecting the provision of appropriate end-of-life care.

Lessons learned - Lessons learned were identified in 70% of deaths reviewed by multi-agency panels.

Potentially avoidable deaths - Potentially avoidable deaths are those where there are aspects of care that, had they been identified and addressed, may have avoided the person dying at that time from that cause.

Of the 112 deaths reviewed in multi-agency panels, most panels (68%) reported that the death was not potentially avoidable…

…19% felt the death had been potentially avoidable
(That's 21 people who, with the right care, may not have died)

Best Practice

A third of reviews provided one or more examples of best practice. There were three key areas in which best practice was most frequently mentioned for all people with learning disabilities:

- Strong, effective inter-agency work.
- Person-centred care.
- End-of-life care.

Many involved the provision of 'reasonable adjustments'. The Equality Act 2010 requires services to make adjustments to the way they support disabled people so that disabled people are not disadvantaged from accessing services.

Support and further information

For further information on the LeDeR Programme or to access the full report go to http://www.bristol.ac.uk/sps/leder/

For support or advice regarding the care of patients with learning disabilities, please contact Ben Haywood-Noble, Learning Disabilities Liaison Nurse on 01423 553690 or benhaywood@nhs.net

If you would like to attend further training on the care and treatment of people with learning disabilities please contact Learning and Development to book onto Learning Disabilities Awareness (Level 2).

If you would like further guidance regarding DNACPR, please contact the resuscitation team who are offering drop in sessions.

13

Harrogate and District NHS Foundation Trust

Date of Meeting:	25 September 2019	**Agenda item:**	6.2
Report to:	Board of Directors		
Title:	Freedom to Speak Up Guardian Report		
Sponsoring Director:	Mr Steve Russell, Chief Executive		
Author(s):	Dr Sylvia Wood, Deputy Director of Governance and Freedom to Speak Up Guardian		
Report Purpose:	**Decision**		**Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓
Executive Summary:	Freedom to Speak Up Guardians are to provide regular, comprehensive reports to their Board so that barriers to speaking up are identified and addressed. This report outlines current work at national and local level, progress with the development of a positive speaking up culture, and further actions planned.		

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:	There is a risk that poor standards of care can proliferate unless patients and staff are listened to and their concerns welcomed and acted upon.
Legal / regulatory:	All NHS trusts were required to appoint a Freedom to Speak Up Guardian and an assessment of speaking up is at the heart of the well led domain of CQC inspections of NHS trusts. See also Freedom to Speak Up: guidance for NHS trust and NHS foundation trust boards | NHS Improvement
Resource:	There is a time resource required to progress the actions and recommendations from national and local findings.
Impact Assessment:	This work aims to impact positively on all staff but particularly on staff who might be more vulnerable to speaking up.
Conflicts of Interest:	Declared.
Reference documents:	HDFT Speaking Up Policy
Assurance:	This report provides assurance that the Board is informed about national and local work in relation to developing a culture of speaking up about concerns.

Action Required by the Board of Directors:

It is **recommended** that the Board:

- **Notes** the content, progress and further actions planned
- **Plans** to complete the new NHSI Board self-review
- **Supports** the developing work on a Fair, Just and Safe culture.

14

Harrogate and District NHS Foundation Trust

Report: Freedom to Speak Up Guardian report to Board of Directors

From: Dr Sylvia Wood, Freedom to Speak Up Guardian

Date: September 2019

Freedom to Speak Up Guardians are to challenge and change culture within their organisations so that barriers to speaking up, whatever they are, wherever they are, are identified and addressed. An important part of the process is for each FTSU Guardian to provide in person regular, detailed and comprehensive Board reports, to support the development of a positive speaking up culture.

This report includes relevant information from the HDFT FTSU Guardians since the last report to the Board of Directors in March 2019.

National Publications

National Guidelines on Freedom to Speak Up training

The NGO has published guidelines on the content of speaking up training for all organisations in the health sector in England to improve the quality, clarity and consistency of speaking up training. The NGO has suggested that speaking up training has an essential part to play in patient safety and the experience of workers and as such, should be considered on a par with other mandatory training.

The guidelines are set out in three parts covering three broad groups of workers: core training for all workers (including volunteers, learners, students and those in training regardless of their terms of contract); line and middle managers training (all workers with line and middle management responsibilities); and senior leaders training (including executive board members (and equivalents), Non-Executive Directors, and Governors). They include details of the methodology that organisations could employ when designing training. In addition, the NGO is working with HEE to explore the production of a widely accessible training package at a national level that organisations could utilise.

Case reviews | Care Quality Commission

The NGO continues to undertake case reviews. Individuals or organisations are able to refer cases where they think there is evidence that the handling of a speaking up case did not meet good practice. The purpose of a case review is to identify areas that can be improved, make recommendations on how improvements can be made and commend examples of good practice. Case reviews are to promote learning; trusts have been encouraged to reflect on the recommendations and to look at how they might improve and apply the learning to their own cultures and processes.

In previous reports I have summarised findings from case reviews undertaken at the following trusts and highlighted any recommendations relevant to HDFT:

- Southport and Ormskirk Hospital NHS Trust
- North Lincolnshire and Goole NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust.
- Nottinghamshire Healthcare NHS Foundation Trust
- Royal Cornwall Hospitals NHS Trust

Another case review has been completed at Brighton and Sussex University Hospitals NHS Trust.

Brighton and Sussex University Hospitals NHS Trust
In December 2017 the NGO received a referral collectively from a group of current and former black and minority ethnic (BME) trust workers. Their referral information suggested that the trust had historically not always responded to instances of BME workers speaking up in accordance with good practice, or the policies and procedures of the organisation. There were allegations that BME workers had been historically 'punished and victimised', as well as 'sacked' for speaking up.

The findings and recommendations have been reviewed and some actions identified for HDFT to consider:

- Review the Speaking Up Policy and consider the improvements suggested in the report;
- Review the gap analysis of previous case reviews to ensure no actions are missing;
- Consider how we exit interviews and how to triangulate employment data with FTSU data in future Board reports;
- Plan a communication strategy and roadshow with our new FTSU guardians, aiming to visit services across the trust to meet workers, describe the role and then measure the effectiveness of this;
- Ensure training in how to handle difficult conversations is included in managers and leadership training;
- Review the diversity of Fairness Champions and link Fairness Champions and FTSU Guardians with our developing staff networks.

Freedom to Speak Up: guidance for NHS trust and NHS foundation trust boards | NHS Improvement
The NHSI has published revised expectations of boards and board members in relation to Freedom to Speak Up as well as supplementary resources and an updated self-review tool.

The HDFT Board of Directors undertook a review against the initial guidance and self-review tool that were published in May 2018, and the outcome was endorsed at a Board workshop in October 2018. Boards were asked to treat this guide as a benchmark, review where they were against it and reflect on what they need to do to improve. The actions that have been progressed and those that required further work have been included in previous reports.

It would seem appropriate to start afresh with the new guidance and self-review, and this has been scheduled to happen at the Board workshop in October 2019.

Alliance against Bullying, Undermining and Harassment in the NHS
This document was put together following a conference hosted by the Royal College of Surgeons of Edinburgh and the National Freedom to Speak Up Guardian in September 2018. The conference brought together a range of medical and healthcare organisations with campaigns and initiatives aimed at addressing the unacceptably high levels of workplace bullying and harassment in the NHS.

The anti-bullying alliance recognises that no one organisation has all the answers but working in partnership through and with healthcare staff across the UK, will help create the culture and leadership needed to eradicate bullying. This will not only help staff recruitment and retention and raise morale, but will also improve patient care.

The document gives an overview of some of the many initiatives being enacted across the healthcare professions to tackle undermining and bullying, and all of the organisations included in the alliance are committed to promoting kindness and respect.

NHS England » A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce
This was published by NHS England in July 2019 and has some useful content in relation to what we are aiming to do within the HR policies review, not just in relation to race and ethnicity but for all staff. There is useful content on models of good practice, guidance regarding management and oversight of local investigation and disciplinary procedures, and compassionate and learning culture.

The NHS Patient Safety Strategy | NHS Improvement
The NHS Patient Safety Strategy was published in July 2019 and describes a patient safety culture and a patient safety system. The key features of the patient safety culture are described as:

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

Related national initiatives
The following initiatives were detailed in previous FTSU Guardian reports to the Board and are highlighted to staff on the intranet at Safety.

Tackling Bullying Call to Action
Caring to change: how compassionate leadership can stimulate innovation in health care
RCS (Ed) Anti-bullying and Undermining Campaign:
Sign up to Safety:
This national campaign has now finished but the team developed resources to facilitate conversations where people have a chance to speak, to be listened to, to feel heard and understood. Rather than focusing on “safety” as a problem that can be fixed by a set of tasks or interventions, they promoted behaviours that help us work safely.
Civility saves lives: @civilitysaves
CQC well-led:
The National Guardian’s Office has worked with the CQC to ensure that an assessment of speaking up is at the heart of inspecting the well led domain, including progress with the Call to Action; how trusts support the guardian role; how trusts respond to the concerns raised by their workers; evidence of a positive speaking up culture in the trust; and steps to support minority and vulnerable staff groups to have a voice.

Local work

Freedom to Speak Up Guardians contacts and feedback

The Guardians work alongside many other systems and processes that staff can use to raise concerns e.g. directly with managers, other departments e.g. HR, Risk Management, or through "Ask the Directors". The cases logged and reported below are those which are specifically raised to Sylvia Wood, FTSU Guardian. The other guardians have also had some contacts during Q2 and we will provide summary data that reflects the total contacts for the Q2 NGO report and in future Board reports.

The summary data is provided to the NGO office quarterly together with the number of contacts from specified staff groups. We are starting to present this data by directorate and HIF.

Year / quarter	Summary data				Directorate				
	Total number of cases	No. raised anonymously	No. with patient safety element	No. with B&H element	CCCC	LTUC	PSC	Corporate	HIF
2016/17	1	0	0	0					
Q1 2017/18	4								
Q2 2017/18	2								
Q3 2017/18	2								
Q4 2017/18	0								
2017/18	8	0	1	5					
Q1 2018/19	4	0	0	3					
Q2 2018/19	11	0	2	8					
Q3 2018/19	16	2	1	10					
Q4 2018/19	8	1	0	2					
2018/19	39	3	3	21					
Q1 2019/20	7	0	2	4	2	3	0	2	0
Q2 2019/20 to date	9	0	1	2	0	2	2	4	1
2019/20 to date	16	0	3	6	2	5	2	6	1

It should be noted that cases are closed as and when it is agreed between the guardian and the contact that it is appropriate to do so, and all are sent a feedback questionnaire which can be completed anonymously. Occasionally contacts leave the trust and no longer respond to attempts to contact. Some cases continue to require ongoing support. There are currently15 ongoing cases with some dating back 12 months.

The number of staff raising concerns continues to be similar to last year. This was an expected result of raising awareness but reflects underlying and sometimes longstanding staff concerns.

- Staff speaking up represent doctors, nursing, allied health professionals, support services and administration staff, and a range of levels from Band 2 to senior staff;
- Staff have been based in acute and community services; all HDFT directorates; and HIF;
- Concerns have been raised by more than one member of staff from some teams;
- No anonymous contacts have received in 2019/20 to date which is positive, with about half wanting their concern to be managed confidentially;
- A smaller proportion of cases to date in 2019/20 have an element of perceived bullying and harassment – either impacting on the member of staff raising the concern or on their colleagues.
- Three cases have had a direct element of patient safety involved which is the same as the total for last year. Two of these cases relate to concerns about staffing levels on inpatient wards.

The information related to completed feedback questionnaires is also reported to the NGO in the quarterly report with the top 3 themes identified from the feedback question.

Year / quarter	Feedback questionnaire					
		Response to "Given your experience, would you speak up again?"				
	Total no. cases feedback received in Q	No. responded Yes	No. responded No	No. responded Maybe	No. responded I don't know	No. indicating detriment as result of speaking up
2018/19	13	13	0	0	0	2
Q1 2019/20	1	1	0	0	0	0
Q2 2019/20 to date	2	1	1	0	0	1
2019/20 to date	3	2	1	0	0	1

One feedback comment received:

> *"It has been a long time since we have met and there have been lots of positive things happening since then.*
>
> *Most importantly, I am extremely impressed and pleased by the work undertaken in the organisation in developing a culture of being open in escalating safety issues. The results of this incredible work are already fact and I can see the difference. This makes me feeling reassured and safe at work, for my patients and me personally. May I say a massive thank you to you, Angela Wilkinson, Angela Schofield and Steve, leading on this amazing work in promoting culture of fairness, justice and being open. I hope this positive culture becomes embedded into our work lives and is adopted by senior and line managers too. I know this may take bit longer - behaviours and culture are the most difficult to change".*

Themes and learning identified

- Staff raise concerns confidentially because they fear impact on their job and recrimination from peers or managers. The detriment reported as a result of speaking up and one response of "no" to the question "given your experience, would you speak up again?" relates to the response of colleagues to speaking up locally;
- Perceived bullying and harassment – personalities and perceived power;
- Some poor team dynamics, relationships and management;
- Concerns about behaviours of individuals inadequately dealt with – so staff perceive nothing being done when they or colleagues have spoken up in the past;
- HR processes perceived as inconsistent, slow and unfair;
- Management inconsistent and related to favouritism and conflicts of interest;
- Attitudes and behaviours by some individuals and within some teams are poor – with examples of incivility, undermining, unkindness. The clinical directorates have been working with some of these teams with good results;
- Managers need more training and support to manage staff effectively, to encourage speaking up as a way of improving, to promote and model kindness and civility, and to address bullying behaviours.

HDFT Freedom to Speak Up Guardians

Two additional Freedom to Speak up Guardians have been appointed at HDFT, Chris Mahon, Consultant General and Colorectal Surgeon and Shona Kerr, Health Visitor 0 -19 Service Gateshead. Shona has attended her training with the NGO and Chris is booked to attend in October. Protected time for the new guardians' role is still being clarified but it is anticipated that

there will be more opportunity for the guardians to support staff and undertake proactive work to promote speaking up and the fair, just and safe culture.

Staff can contact the guardians collectively or individually, addressing any real or perceived conflicts of interest relating to any of the guardians. We have done some work to enable shared access to resources but confidentiality for individual contacts, and we will be meeting regularly to ensure both themes and learning are identified, and reports to the Board and the National Guardians Office (NGO) are prepared collectively. Jill Foster is supporting all of the guardians. A regular meeting has been arranged for Sylvia Wood to meet and discuss themes and cases with Steve Russell, CEO and Angela Schofield, Chairman, and this will be adapted to incorporate feedback from the other guardians as required.

We will start to report contacts and feedback by Guardian, but this is some initial Q2 contact data.

Year / quarter	Summary data			
	Total number of cases	No. raised anonymously	No. with patient safety element	No. with B&H element
Q1				
S Wood	7	0	2	4
Q1 2019/20 total	**7**	**0**	**2**	**4**
Q2				
S Wood	9	0	1	2
S Kerr	NA	NA	NA	NA
Q2 2019/20 to date	**9**	**0**	**1**	**2**
2019/20 to date	**16**	**0**	**3**	**6**

Fairness Champions

We now have 39 Fairness Champions appointed across the organisation, including all directorates and HIF. 10 are yet to attend an induction – but have been invited to the next one which is planned for 2 October. Recruitment is ongoing; the ambition is that our champions will role model the behaviours we want, listening to staff with concerns and signposting them to appropriate sources of advice and support. This will help us to change the culture one behaviour at a time.

We had the first meeting for Fairness Champions in March and have another planned for October, with an expectation that these will be planned to provide regular support, both in the hospital and in community locations. These are planned as an informal catch up over coffee for anyone who can come along. The aim is to enable the group to have a chance to talk about how things are going, how to support each other, and how to further improve the culture within teams and across the organisation. The first meeting generated lots of enthusiasm and ideas.

Fair, just and safe culture

Work has been done to start to develop a vision and strategy for a fair, just and safe culture which will be a key enabler to deliver the Trust vision and objectives and “true north”. There are national drivers including the NHS Long Term Plan; Workforce Race Equality Standard; Workforce Disability Equality Standard; NHS Patient Safety Strategy etc. This will be developed further with the Board in October.

Conflict of Interest

Managing Conflicts of Interest in the NHS: Guidance for staff and organisations (NHS England 2017) describes:

> Conflicts of interest can arise when decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process.

The impact of conflict of interest in relation to loyalty has been raised nationally by the National Guardian's Office, and also in relation to the perception of conflict of interests locally. There are lots of situations where there is the potential for loyalties to influence recruitment, management, and how concerns, behaviours and investigations are managed.

The appointment of the two additional, and independent, Freedom to Speak Up Guardians at HDFT provide assurance that staff have a number of options for raising concerns with a guardian. Some amendments to strengthen the trust conflict of interest policy have been suggested. It is however important to be realistic about expectations, and not suggest that every loyalty must be declared. Awareness of loyalty conflict and ensuring that this is managed appropriately is perhaps more important.

HR policies review

HR are leading a review of a number of our HR policies and procedures to ensure they support our overall culture and that they remain effective. These policies include:

- Managing Attendance and Promoting Health and Wellbeing
- Disciplinary
- Grievance

One of the FTSU Guardians has been invited to be part of this review and will be aiming to ensure the work reflects NHS England » A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce and a fair, just, compassionate and learning culture.

Speaking up Policy

The HDFT Speaking Up Policy has been reviewed and updated, taking account of feedback from contacts, case reviews and internal audit. It is due to complete the approval process during September.

Recommendations

Freedom to Speak Up self review by the Board of Directors

The new Freedom to Speak Up: guidance for NHS trust and NHS foundation trust boards | NHS Improvement and updated self-review tool needs to be reviewed by the Board and actions identified to ensure the organisation is following best practice. The outstanding recommendations from the last NHSI review in October 2018 are below:

Recommendation (*and reference from self-review tool*)
1. Clarify / develop FTSU vision and strategy (1.2, 1.4, 2.1, 2.4) There has been discussion about how this fits with the work undertaken on the fair and just culture. It would seem appropriate for speaking up to be clearly articulated as a key component of an overarching Fair and Just Culture Strategy;
2. FTSU Guardian to continue to identify underlying concerns and share learning, identify barriers to speaking up for those in more vulnerable groups - to ensure agency staff, students have information about speaking up and are supported, and to ensure appropriate action follows allegations of victimisation (1.2, 6.2, 6.4, 6.5, 8.7, 10.8, 13.3)
3. Ensure learning is reported into the governance framework and embedded into operational practice including within the teams and departments that MD and Chief Nurse oversee (3.4, 6.5, 9.5, 13.3)
4. Link into current Leadership Development Activity and RCN Clinical Leadership, and include importance of learning from issues raised by people who speak up in Leadership Strategy (1.3)
5. Training: For managers and HR partners about how to promote constructive speaking up and appropriate response to concerns from staff - to have more focus on speaking up in Pathway to Management Programme - most contacts relate to perceived bullying and poor behaviours and demonstration of values by managers (3.6, 6.1, 12.2, 12.3, 13.3)
6. Consider asking IA to review wider staff investigatory processes (not just FTSU) but unclear how to manage confidentiality, and seek advice about how to quality assure a sample of cases (8.7, 10.5)

Triangulation with HR metrics

There is still work to do to identify workforce metrics that can be used together with information from the FTSU Guardians to indicate local cultures and enable earlier focused work. The information might include staff survey data, turnover rates, sickness rates, exit interviews, grievance and disciplinary rates etc.

Training

Work needs to be done to plan and introduce the recommended training.

Barriers and how they can be overcome

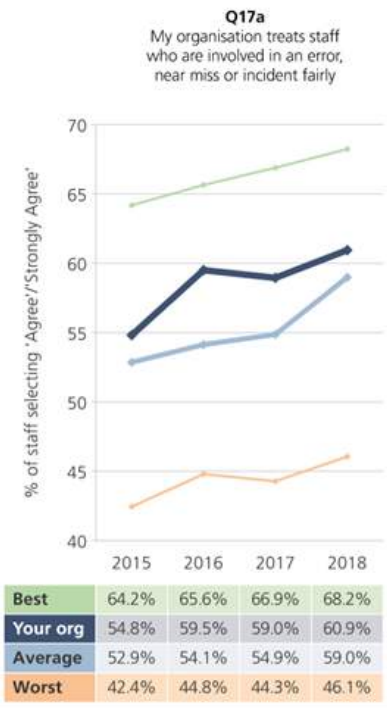
Barriers to speaking up may be felt by those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers. Actions to overcome these include the work that has already started to progress:

- Staff networks
- Staff engagement
- Inclusion and diversity

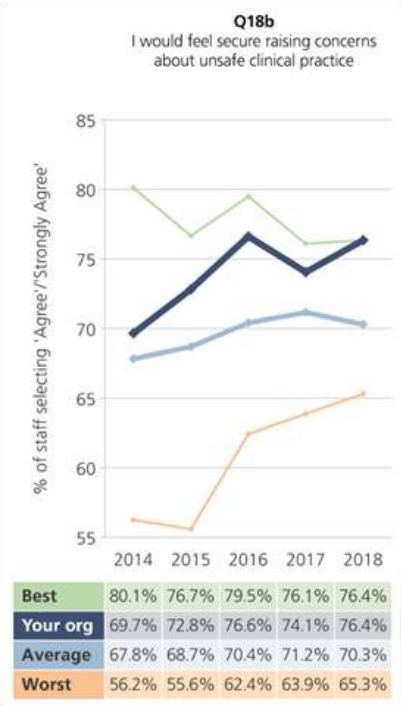
A culture that inhibits speaking up because of recrimination and blame acts as a significant barrier; the work to promote a fair and just culture, training managers to address concerns positively and supportively, and the work to ensure the fair application of HR policies and processes are significant pieces of work to address this.

Indicators being used to measure success

The FTSU self-review suggests reviewing whether the correct indicators are being used to measure success. The results of the staff survey are probably the most objective indicators that we have. The 2018 staff survey showed some positive progress with the safety culture, particularly in relation to staff feeling secure about raising concerns about unsafe clinical practice. We do not have any more up to date information about this.



	2015	2016	2017	2018
Best	64.2%	65.6%	66.9%	68.2%
Your org	54.8%	59.5%	59.0%	60.9%
Average	52.9%	54.1%	54.9%	59.0%
Worst	42.4%	44.8%	44.3%	46.1%



	2014	2015	2016	2017	2018
Best	80.1%	76.7%	79.5%	76.1%	76.4%
Your org	69.7%	72.8%	76.6%	74.1%	76.4%
Average	67.8%	68.7%	70.4%	71.2%	70.3%
Worst	56.2%	55.6%	62.4%	63.9%	65.3%

Summary

There continue to be a similar number of contacts to the Freedom to Speak up Guardian during Q1 and Q2 2019/20 which provides information about concerns and behaviours and enables learning. Specific actions have been taken in some areas and there is other work being progressed. The information available from other trusts in the NGO case reviews continues to provide useful insight and learning.

There are a number of new publications and continuing national initiatives such as Civility Saves Lives which are informing the work we have started to define and develop a fair, just and safe culture. This has the potential to positively shape the behaviour of everyone who works in the organisation, the quality of care it provides and its overall performance. The new Freedom to Speak Up Guardians will provide more awareness, information and support for staff with concerns. Fairness Champions are continuing to volunteer to play an important part in driving the cultural change toward an expectation of fairness, listening to colleagues who have concerns and signposting them to those who can help them to speak up. There is an exciting opportunity to clarify and then drive a philosophy in relation to a fair, just and safe culture that could be applicable to events or incidents, complaints, and employment issues.

There are a number of other recommendations to work on, including planning and introducing freedom to speak up training that meets the national guidelines, completing a review and update of the Conflict of Interest Policy, and identifying and using metrics to monitor staff engagement and local cultures, enabling a proactive approach to addressing concerns early.

NHS
Harrogate and District
NHS Foundation Trust

Date of Meeting:	25 September 2019	**Agenda item:**	6.3
Report to:	Board of Directors		
Title:	Ninth 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:	**Decision**	**Discussion/ Consultation**	**Assurance** ✓	**Information**
Executive Summary:	The Board of Directors is asked to note: • 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 5% which is comparatively low. • A new contract deal has been agreed for junior doctors in England.		

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

Key implications	
Risk Assessment:	Risks associated with the content of the report are reflected in the Board Assurance Framework
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:

The Board of Directors is asked to **receive and note** the content of the report.
The Board of Directors is requested to **consider the points** at the end of the report.

Harrogate and District NHS Foundation Trust

Board of Directors 25 September 2019

Quarter 1 2019/20: 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 ninth 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 2019.

The orderly stream of quarterly reports was interrupted by the Board's instruction to change the periodicity of written reports to four-monthly intervals. This is out of synchronization with the regional quarterly reporting pattern. The Trust's reports will following alternately in and out of phase with the quarters. Lately, the Guardian has been advised to continue to submit quarterly reports and the Board will fit them into its business as required.

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. These will now move to Version 5 of the contract according to its Outline Implementation Table over the period 2019 to December 2020.

31 [Q1] exception reports have been received from trainees and dealt with. This is a decreasing trend. These have mainly concerned over-runs of working hours ('hours and rest') owing to the busy state of the wards and to individual patient matters. There was just one reduced educational opportunity exception report in quarter. Exception reporting remains comparatively low in this Trust although highly variable across the region.

There having been no breach of the European Working Time Directive, no fine has yet been levied. National trends in medical post-graduate training and indeed medical workforce numbers overall continue to be adverse.

There has been no regional or national meeting for guardians in the last quarter. Two trainee doctors' fora have been held jointly with the Director of Medical Education. These will continue bi-monthly.

The Guardian is booked to attend the national Guardians conference in Leeds on 30th September 2019.

On-going national developments include the newly agreed Version 5 of the 2016 Contract by NHS Employers and BMA to be implemented 2019-20.

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.'

The Trust Board has requested that the Guardian enlarges his role: in addition to the existing role to doctors in training grades, the Guardian will embrace the remaining non-training, non-career grade doctors in his system and responsibility. The Guardian has agreed to this change. The Guardian will discuss implementation of this process with the medical workforce department.

BMA and NHS Employers have concluded their dispute from 2016 with a new juniors' contract (2016 TCS Version 5). This offers numerous detailed improvements to the trainees in their employment.

1 Introduction

This is the ninth quarterly report of the Guardian of Safe Working Hours which presents the Trust's statistics in brief form: more detailed data are held in the DRS computer system and are 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.

2 High level data

In September 2019:

The position is changed from the last report by the addition of ~30 GP trainee posts which the Trust has gained as lead employer. This changes the denominator of gaps:

Number of doctors / dentists in training (total established Deanery posts)	150 [last quarter: 119]
Number of doctors / dentists in training actually in post	142 [last quarter: 106]
'Gaps' in deanery posts	5.3%
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

The bi-annual change over takes place in early February and August each year.

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.

Clinical supervisors are in many cases poor at responding to exception reports. This task was dropped on consultants without their agreement by the 2018 Trainees new contract. The Guardian has to review and agree outstanding reports.

This report presents Quarter 1 2019/20 (1 April 2019 to 30 June 2019).

Q4: 1.1.2019-31.3.2019 Exception reports by department: hours/rest				
Specialty [five top]	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Medicine	0	11	11	0
General Surgery	0	13	13	0
GP	0	2	2	0
Urology	0	2	2	0
Paediatrics	0	1	1	0
Total	0	31	31	0

These include one education exception in this quarter which was combined with an 'hours and rest' exception. Reports are down slightly on Q4 (41). Nearly all reports are of over-working at the end of the day when clinical workload, acutely ill patients and too few colleagues demand working beyond normal hours. This is especially true in general medicine. To put this in rough context, if 150 trainee doctors work about 20 days per month, then 31 exception reports have occurred on only 0.34% of the c9000 doctor-days worked in the quarter. [Exception reports are known to under-report over-working].

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. Clinical supervisors are intended to respond to each exception report. Despite repeated advice some never do and the report has to be managed by the Guardian. 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 specific issue has arisen in this quarter.

5 Vacancies

The vacancies are improved upon previous quarters: 5% of training posts [9% Q2/3 2018-19].

The successful filling of rota gaps is of course a measure of the diligence and ingenuity of the Medical Workforce and Recruitment team but challenged by the availability and willingness of suitable doctors to apply.

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.

There are also 12 Trust posts for doctors not in training schemes who participate in the same rotas as trainees. There are about 60 SAS grade doctors in the Trust.

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 caused by the Trust. 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 Meetings

The Guardian had no regional or national meetings to attend in the quarter.

The next trainee forum is due on 23rd September 2019 and the National Conference for Guardians of Safe Working Hours is on 30th September 2019 in Leeds: the Guardian is registered to attend this.

8 Trainees' Forum

The importance of exception reporting has been canvassed to the trainees.

9 Disclosure

These regular 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. The change in periodicity of reporting to the Board has disrupted the flow of reports to Health Education England.

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 are available to the Board of Directors in private session on request.

11 CQC

The Guardian has had no further contact with CQC inspectors.

12 New contract deal for junior doctors in England

BMA and NHS Employers announced on 3rd September 2019 that a new deal had been agreed with NHS Employers and the Department of Health and Social Care [https://www.bma.org.uk/collective-voice/influence/key-negotiations/terms-and-conditions/junior-doctor-contract-negotiations/agreed-new-contract-deal-for-junior-doctors-in-england.] The amended version had been put to a ballot of members with 82 per cent of respondents voting in favour of the amended contract. This agreement marks the end of the 2018 review process and finally brings the BMA's dispute with the government over the 2016 contract to a close. The contract has been accepted for all junior doctors in England and will be implemented according to the Outline Implementation Timetable over the remainder of 2019 and to December 2020.

The amended contract is termed: '*Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 Version 5*,' dated August 2019.

Overall, the new contract makes numerous detailed improvements on behalf of doctors in training in many aspects of their employment. These include improvements in equalities, less than full time training and flexible training; good rostering guidance; improved pay; transitional pay arrangements; safety and rest limits; leave; locum work; guardians; fines; exception reporting; work scheduling; facilities; the commitment to future working groups, and new guidance on all these matters.

The scope of exception reporting is enlarged to include all aspects of remunerated time including activities required for assessment and patient safety work. Review of exceptions is to be more clearly specified and the guardian has authority to action reports not responded to within seven days. Guardians have increased jurisdiction of some rostering limits.

13 Inclusion of SAS doctors within the scope of the Guardian

The Trust Board has requested that the Guardian enlarges his role: in addition to the existing responsibility to doctors in training grades, the Guardian will embrace the remaining SAS (non-training, non-consultant grade) doctors within his system and responsibility. Strictly, this has no contractual or statutory basis, but the Trust has agreed – in an exchange of letters with the Medical Director - that it will honour agreements and determinations made by the Guardian as if these doctors were training grade doctors covered by the 2016 TCS V5. The Guardian has agreed to this change. The Guardian will discuss implementation of this process with the medical workforce manager. The workload and IT implications of this change are still to be determined.

14 Issues arising

a. The Trust continues in comparatively good standing. We have had a below-average rate of exception reporting but there is an increasing trend.
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. This is especially true in general medicine. The clinical directorate is actively managing the situation.
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 this quarter.
f. The national Guardian meeting is planned for 30th September 2019.
g. NHS Employers and BMA have agreed an amended national junior doctors' contract following the 2018 review. The 2016 TCS V5 makes numerous detailed improvements to the employment of doctors in training. The Guardian and the medical workforce department will be studying the changes and implementing them.
h. The Trust Board has requested that the Guardian enlarges his role in relation to SAS doctors. This is agreed: the Guardian will discuss implementation of this process with the medical workforce department.

15 Actions taken to resolve issues

a. No fine has been necessary this quarter.
b. No intervention has been necessary this quarter to investigate any situations.
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 to be converted to 2016 TCS Version 5.

ii. Overworking owing to pressure of work and rota gaps is a chronic problem in medicine. This is under active management by the directorate.
iii. The Guardian can only intervene on notified problems.
iv. The Guardian will continue to attend regional and national meetings.

16 Questions for consideration by the Board of Directors

a. The Board is asked to receive the combined quarterly report and to consider the assurances provided by the Guardian. The Board has changed its requirement for written reports: future reports will be four monthly.
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 5 per cent.

Dr Carl Gray

Guardian of Safe Working Hours
18th September 2019

NHS
Harrogate and District
NHS Foundation Trust

Date of Meeting:	25 September 2019	**Agenda item:**	6.4
Report to:	Board of Directors		
Title:	Medical Revalidation Annual Statement of Compliance		
Sponsoring Director:	Dr David Scullion, Medical Director		
Author(s):	David Lavalette, Revalidation Officer and Lee-anne Hutchison, Medical Workforce and Revalidation Manager		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	• The Trust is required by NHS England to complete an annual Statement of Compliance with regulatory procedures. • The Trust remains fully compliant with all the requirements of a Designated Body.		

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:	Failure to comply with the requirements of annual medical appraisal and revalidation would place the Trust at risk of medical staff losing their Licence to practise medicine in England and the Trust losing status as a Designated Body under the General Medical Council.
Legal / regulatory:	A failure to employ a Responsible Officer, as required under the terms of the Medical Profession (Responsible Officers) Regulations 2011, would lead to loss of status as a Designated Body
Resource:	The Trust employs a Responsible Officer and a medical Workforce and Revalidation Manager to administer the medical appraisal and revalidation process
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	Not applicable
Assurance:	Not applicable

Action Required by the Board of Directors:

It is recommended that the Board:

- **Notes** items included within the report
- **Authorises** the Chairman and Chief Executive to sign-off the Statement

OFFICIAL

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Version 4, April 2014

THE NHS CONSTITUTION
the NHS belongs to us all

16

Statement of Compliance

Version number: 4.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 01142

NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

OFFICIAL

Designated Body Statement of Compliance

The board / executive management team – HARROGATE AND DISTRICT NHS FOUNDATION TRUST can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   YES

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   YES

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   YES

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   YES

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   YES

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   YES

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   YES

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

YES

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

YES

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

YES

Signed on behalf of the designated body

Official name of designated body: Harrogate and District NHS Foundation Trust

Name: Angela Schofield Signed: …….

Role: Chairman of the Board

Name: Mr Steve Russell Signed: …….

Role: Chief Executive

Date: 25 September 2019

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Harrogate and District NHS Foundation Trust

Date of Meeting:	25 September 2019	**Agenda item:**	6.5
Report to:	Board of Directors		
Title:	HDFT Digital Strategy 2019 - 2024		
Sponsoring Director:	Mr Robert Harrison, Chief Operating Officer		
Author(s):	Dr Matthew Shepherd, Clinical Informatics Lead Mr Paul Nicholas, Deputy Director of Performance and Informatics Mr Richard Atkinson, Head of IM&T Projects Mr Martin Gartside, Head of IT Services		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** **Information**		
Executive Summary:	This Digital strategy replaces the IM&T strategy 2017-2022 as it develops a broader digital vision for the organisation and revises the governance of digital developments within the organisation. It sets out a vision to support the delivery of High Quality Care, Patient Experience and Staff Wellbeing through Digital Transformation.		

Related Trust Objectives

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

Key implications	
Risk Assessment:	The strategy seeks to support a number of Corporate Risks associated with Workforce pressures through improving efficiency and supporting colleagues to enable them to work effectively.
Legal / regulatory:	N/A
Resource:	A detailed resource assessment is being carried out to support planning for the delivery of the Strategy. The Annual Plan currently includes resources to support elements of the plan
Impact Assessment:	To be completed as part of business case approval process as part of each development
Conflicts of Interest:	None Identified
Reference documents:	As listed in the Strategy
Assurance:	BAF 16

Action Required by the Board of Directors:

It is **recommended** that the Board of Directors:

- **Approves and adopts** the Strategy to provide a framework for the strategic direction of the delivery of digital developments within the Trust, recognising that the resource implications will be identified and agreed through the annual planning process.

NHS
Harrogate and District
NHS Foundation Trust

HDFT Digital Strategy 2019—2024

You matter most

Authors: Dr Matthew Shepherd, Consultant & Clinical Lead for Emergency Medicine & Clinical Informatics Lead

Paul Nicholas, Deputy Director for Performance & Informatics

Richard Atkinson, Head of IM&T Projects

Martin Gartside, Head of IT Services

Date: 8th August 2019

Contents

01 Introduction

Our key strategic objectives are to:

To deliver high quality healthcare

This means that we will continuously strive to deliver the best possible outcomes and ensure that people using our services have a positive experience. We will make the safety of services our highest priority. We will listen to the views of people using our services and staff providing care and use this to make improvements. We will invest in supporting and developing our workforce and promote a positive and open culture of learning. We will make sure that Harrogate and District NHS Foundation Trust is a great place to work.

To work with partners to deliver integrated care

This means that we will work positively with other providers, local authorities and commissioners to ensure that the design of services offers the best possible, affordable care. We will work with partners striving to give every child the best start in life. We will design services based on the physical, mental and care needs of local people and ensure that these are joined-up where this makes sense.

To ensure clinical and financial sustainability

This means that we will manage resources carefully and make sure that clinical models are robust and reliable. We will take a long-term view of financial risk and strategic planning. We will look carefully at trends in activity and align workforce and infrastructure capacity. We will seek to expand our services to a wider population where this provides greater clinical resilience. This strategy focuses on providing high quality, safe and sustainable services to its local population of Harrogate and North and West Leeds, as well as North Yorkshire and North East for the community services we provide.

Digital information and technology is a key enabler to support our vision, strategy and business requirements through:

- ensuring that information and technology is used to support the quality and safety of care for patients in their place of care (Hospital & Community) ;
- providing high quality, timely and meaningful information to support and enable the effective management and delivery of high quality clinical practice and corporate support;
- providing a robust fit for purpose network infrastructure that enables clinical and corporate services to execute their duties efficiently and effectively;
- providing procurement and system implementation support through effective and efficient programme and project management;

Information and digital technology is critical in supporting the delivery of service improvements, new developments, efficiency gains and most importantly, high quality patient care over the next five years and beyond.

We all have an important role to play in becoming an organisation that thinks ‘digital’ with those clinical and operational staff using the technology on a day to day basis being central to this. Their ideas, innovations and vision for what digital can achieve for patients based on their in-depth knowledge from interactions with patients will help guide our digital strategy.

This document defines the strategic direction for digital technology and information to support us in achieving its objectives and is increasingly underpinning everything that we do.

02 Our Digital Vision

Delivering High Quality Care, Patient Experience and Staff Wellbeing Through Digital Transformation

Through digital working we will enable our staff to spend more of their time delivering excellent care to patients in their place of care, making their day to day lives easier, whilst ensuring they are able to communicate and collaborate more effectively and use data to learn and constantly improve the care we provide and enable patients and their carers to directly access and provide information relevant to their care.

03 National Drivers & Strategies

Five Year Forward View

The NHS "Five Year Forward View" (FYFV) describes the challenges the NHS faces and how the current NHS model is unsustainable. It describes how action is required to prevent illness such as obesity, smoking and alcohol, how patients need greater control of their own care, and how barriers need to be broken down between all care providers.

The effective, safe and secure sharing of information between all care providers and patients is critical. Currently at HDFT, there is limited sharing of information electronically between organisations, so the majority of information is shared verbally, on paper or not at all. There are clear risks with this, but in particular it means that care providers may not have the most up to date or accurate patient information to provide patients with the best and safest possible care.

Personalised Health and Care 2020

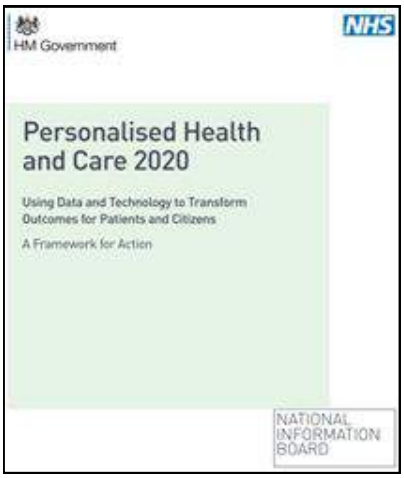
The FYFV identifies harnessing the information revolution as a key enabler to securing a sustainable NHS and made a commitment that, by 2020, all electronic health records would be fully interoperable so that patient records are paperless. This vision was supported by the establishment of the National Information Board and its ambition to transform the health and care digital landscape outlined in Personalised Health and Care 2020 – A Framework for Action.

Better use of data and technology has the power to improve health, transforming the quality and reducing the cost of health and care services. It can give patients and citizens more control over their health and wellbeing, empower carers, reduce the administrative burden for care professionals, and support the development of new medicines and treatments.

In other parts of our lives, we see the benefits of technology: in the way we book our travel and holidays, manage our bank accounts and utility bills, buy groceries, connect and communicate with our friends and family. Digital technologies are changing the way we do things, improving the accountability of services, reducing their cost, giving us new means of transacting and participating.

This is more than an information revolution: it puts people first, giving them more control and more transparency.

For us to deliver a true integrated digital care record and become paper-free, it needs to be in a position where vital patient related information can be accessed and clinical decision and support tools can be used in a joined up manner and in a single instance. This information needs to be available across sectors, services and providers, as well as accessible to the patient themselves.



Making IT Work: Harnessing the Power of Health Information Technology to Improve Care in England

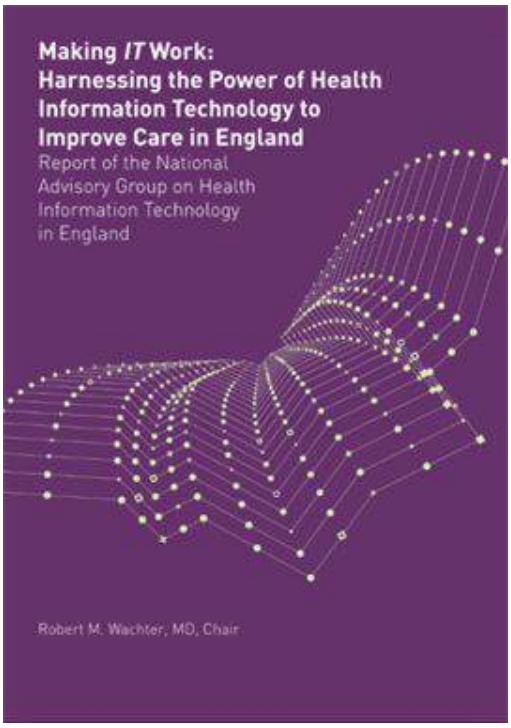
In late 2015 the National Advisory Group on Health Information Technology in England was formed to advise the Department of Health and NHS England on its efforts to digitise the secondary care system. A report was produced by Bob Wachter titled "Making IT Work: Harnessing the Power of Health Information Technology to Improve Care in England". The report describes ten overall finding and principles and ten implementation recommendations:

Overall Findings & Principles

- Digitise For The Correct Reasons;
- It's Better To Get Digitisation Right Than Do It Quickly;
- "Return On Investment" From Digitisation Is Not Just Financial;
- When It Comes To Centralisation, The NHS Should Learn, But Not Over Learn Lessons From NPFIT;
- Interoperability Should Be Built In From The Start;
- While Privacy Is Important, So Too IS Data Sharing;
- Health IT Systems Must Embrace User Centred Design;
- Going Live With A Health IT System Is The Beginning, Not The End;
- A Successful Digital Strategy Must Be Multifaceted, And Requires Workforce Development;
- Health IT Entails Both Technical And Adaptive Change;

Recommendations

- Carry Out A Thoughtful Long Term National Engagement Strategy;
- Appoint And Give Appropriate Authority To A National CCIO;
- Develop A Workforce Of Trained Clinician-Informaticists At The Trust And Give Them Appropriate Resources And Authority;
- Strengthen And Grow The CCIO Field, Others Trained In Clinical Care And Informatics, And Health IT Professionals More Generally;
- Allocate The New National Funding To Help Trusts Go Digital And Achieve Maximum Benefit From Digitisation;
- While Some Trusts May Need Time To Prepare To Go Digital, All Trust Should Be Largely Digitised by 2023;
- Link National Funding To A Viable Local Implementation/Improvement Plan;



- Organise Local/Regional Learning Networks To Support Implementation And Improvement;
- Ensure Interoperability As A Core Characteristic Of The NHS Digital Ecosystem – To Promote Clinical Care, Innovation And Research;
- A Robust Independent Evaluation Of The Programme Should Be Supported And Acted Upon;

These findings, principles and recommendations provide us with some guidance to delivering its digital strategy. Some of these are already being picked up at a National level but others will need to be picked up at a local level.

NHS Long Term Plan (2019)

The NHS Long Term Plan (2019) describes how "Digitally-enabled care will go mainstream across the NHS", coupled with the DHSC policy document "The future of healthcare: our vision for digital, data and technology in health and care".

These documents focus on getting the basics right: i.e. the underlying digital architecture of the health and care system – recognising that the building blocks are critical to the safe and successful use of technology, ensuring that systems communicate with each other and that the right data gets to the right people at the right place at the right time.

04 Digital Strategic Themes & objectives

The core aims of this strategy are to:

- Make staffs working lives better by making their jobs simpler, easier and quicker to do by removing some of the administrative burden and manual tasks through the provision of technology;
- To improve patient care and make their experience better by giving our staff better technical solutions to care and treat for patients and provide patients with access to technology when they visit their place of care and in their own homes to share information about their health and wellbeing;
- To provide technical solution to improve the flow and management of patients as they come through our healthcare system;

Three key digital strategy themes have been

Digitally Enabled & Empowered Workforce

Digitally Connected & Informed Patients

A Future Proof & Secure Digital Infrastructure

Digitally Enabled & Empowered Workforce

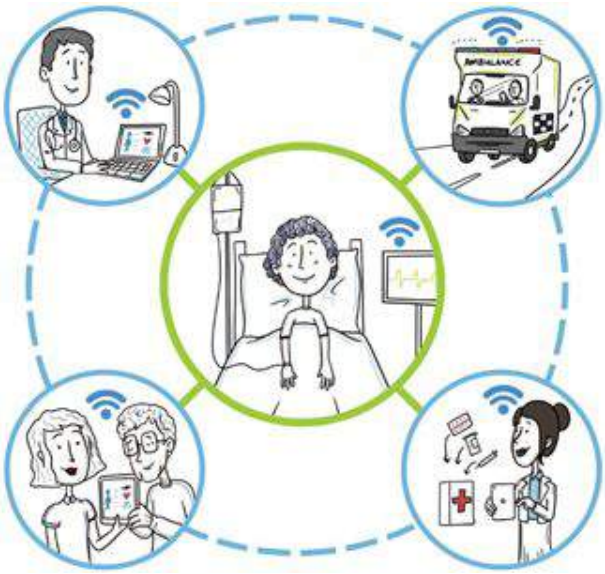
Integrated Electronic Health Care Record

Staff will be able to access the electronic health care record in real time to input and retrieve patient information in the patients place of care. This will include access to relevant social care, mental health and acute service information for that patient from across the Yorkshire region.

The record will facilitate an iterative assessment of patients, minimising repetition and ensuring information between professionals is shared in real time. Direct electronic data entry will be maximised and facilitated through voice to text, digital image import and digital annotation. Medical devices will stream information directly into the patient record and be linked to automated escalation pathways ensuring this information is shared rapidly with the right clinical staff.

Where paper still exists it will be imported into the electronic record safely and easily at the point it is first received in the organisation. The electronic health care record will be integrated with handover, ward and bed management, the patient portal and staff communication systems. This will allow staff to spend more time delivering care to their patients, reducing the repetition that occurs frequently at present.

Sharing of information in real time will create a more responsive health care system and enable the patients and their carers to provide and receive information to improve their health care and improve patient safety.



WebV tpp

We will achieve this by enhancing and continuing the deployment of our integrated (EPR) electronic patient record system (WebV) in partnership with North Lincolnshire & Goole Foundation Trust, and our community EPR (SystmOne) provided by TPP.

By developing our own EPR we have greater control over what it does, how it works, how we deploy it at the pace that suits us. As the WebV design is clinically led by HDFT and NLG, this means we can make sure it works in the best way for our staff and as we feed information in from our current systems and eventually replace them with WebV, there will be less and less logins/passwords, less training and less systems to maintain and pay for.

New and enhanced functionality will improve patient flow and the management of tasks such including inpatient activity, referrals and other clinical activity, further removing the paper based processes currently in place.

As part of a collaboration of healthcare Trusts in the Yorkshire and Humber region, we are delivering the Local Health Care Record Exemplar (LHCRE) programme. This means we will be able to share patient information across organisational and geographical boundaries seamlessly, including acute, community, primary care, social services and mental health.

We are also working with our local GP's to provide them access to WebV from within their GP systems (SystmOne and EMIS), so that they can access the patients acute clinical record and have access to clinical information they don't currently possess.

Staff Communicating & Collaborating

Staff will be able to directly message colleagues with referrals, queries and information relating to patients allowing collaborative virtual consultations enhanced by video and images where appropriate. This will function on and off site and allow closer working between community and acute colleagues without the need to move the

In addition to patient related communication staff will be able to access their own information, learning, appraisals and team meetings virtually where appropriate.

Patients/carers will be able to access clinicians digitally again reducing the need to attend.

This will be supported by new collaboration systems including a new corporate intranet site, video conferencing and social media style applications to support staff working better as teams.

Provision of Digital Technology to Enable Staff to Work Effectively Wherever They Are

5G technology will facilitate the rapid exchange of large amounts of data required to allow mobile working to match the speed of digital systems connected to a traditional wired network.

In conjunction with a choice of role appropriate devices, staff will be able to access the systems they need wherever they are to provide excellent care and ensure the flow of real time information is maintained.

Within our current buildings, a fast effective Wi-Fi network with full coverage will ensure staff, patients and visitors can access systems rapidly for patient care but also use this network to communicate and access information/ entertainment.

When working at other sites or organisations, we will endeavour to provide digital connectivity.

Digital Transformation to Modernise Day to Day Administrative Functions

Through better use of technology, administrative support service and business functions will be transformed from their current manual practice, to a modernised digital automated process. We will invest in training and support to provide the workforce with the skills and technologies needed to improve the efficiency and effectiveness of the corporate support services.

We will improve the ability to make informed decisions by ensuring we have access to the right tools and information at the right time. Where there are repetitive or rule based processes which currently take up staff time, these will be streamlined and performed by software 'robots' which can work 24x7, releasing staff time for more complex tasks.

Robot Process Automation (RPA) software use 'robots' to perform routine business processes by mimicking the way that people interact with IT applications and follow simple rules to make decisions. End-to-end processes can be automated by these robots with minimal human interaction.

Any paper based process suffers the inherent limitations of that information being only available in one place at a time and potentially being out of date from the moment it is produced. The removal of paper and its limitations is essential to enhancing patient safety and improving the working environment for staff.

A Digitally Skilled Workforce

Alongside the systems and technology we will develop and educate our acute and community workforce to be able to effectively use new technologies for the benefit of themselves and patients.

We will also ensure that it remains easy for staff to engage in the development and evolution of our digital healthcare landscape and ensure that digital solutions are user driven. Staff will be educated so they understand how to protect systems and patient information from the ever increasing cyber security risks that are an inherent threat to digital ways of working.

Data & Intelligent Systems Used to Improve Decision Making, Service & Patient Safety

With more data being captured directly we will use this to provide enhanced reporting and analytics to facilitate learning, enable responsive services and improve efficient use of resources.

Where appropriate intelligent systems will support decision making to ensure optimal and consistent care for our patients.

A command centre will receive information from multiple systems to provide real time clinical and business information to aid the day to day running of our organisation and its patient flow.

Digitally Connected & Informed Patients

Patients & Their Carers Directly Accessing Information & Communication Relevant to Their Care

Our patients will have the ability to view their own care record electronically. This will provide them with access their clinical correspondence such as outpatient letters, reducing the need to send paper copies through the post and giving them access to their information as soon as it is available, wherever they are.

We will provide on-line resources to our patients, such as useful self help guides or videos to enable them to better support their own care at home. This may mean that they do not need to come into an alternative place of care as often, and could lead to better outcomes for the patients.

We will also reduce the number of times the patient has to enter or provide their information to our staff and remove this ongoing frustration for our patients.

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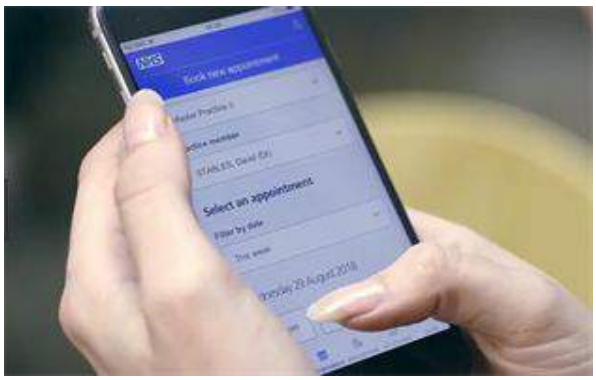
Virtual Consultations

We would like to provide our patients with the option of having their clinic appointment "virtually". By providing patients and staff with access to video consultation technology, some patients may be able to speak remotely with the Consultant or community teams caring for them from the privacy and comfort of their own home or their place of care.

This will mean the patient does not need to travel somewhere else and will provide a much more cost effective way for us to provide this type of care and should improve patient attendance.

Patients Booking & Managing Appointments On-Line



We want our patients to be able to book and change their appointments online so that they can attend their place of care when it is convenient for them and provide an easier way of them letting us know when they can't make their appointment.

We will provide them with reminders of when their appointment is. This will help reduce the number of "Did Not Attend" (DNA's) "Was Not Brought In" and free up clinic slots for other patients who can attend and making the best use of our resources.

Wearable Technology & Sharing Information with Healthcare

We will provide our patients with wearable technology so that some clinical information can be captured and shared with our clinicians remotely.

We will also look to provide patients with “apps” to provide further information about the current health and wellbeing.

This will mean the patient doesn't need to come into their place of care to provide this clinical information, but this clinical information can also be used by the clinician to determine whether or not the patient needs to come in for treatment, or to provide advice to the patient in their own home.

Remove the Reliance on Paper

Patients can be bombarded with various types of paper documents about their care which can in some cases be overwhelming. Sometimes these paper documents can be damaged or misplaced and is neither good for the environment or a good use of tax payers money.

We want to gradually move away from providing paper documentation to our patients. Many people these days prefer to receive information electronically so they can review on the mobile phones, tablets or personal computers.

Patients online in their Place of Care

When our patients or their relatives visit us for care and treatment, we want them to have the best experience possible. Depending on the circumstances, they can spend hours, days, weeks or even months on our premises.

To make their experience better, we would like to provide them with access to free Wi-Fi technology so that they can view electronic media from their own devices such as their mobile phone or tablet computer. This could be them accessing

A Future Proof & Secure Digital Infrastructure

Scalable & Reliable Access to Digital Services

Access to our digital services will be enabled through a scalable, reliable and cost effective networking and server technology infrastructure. This will be delivered through a combination of Cloud and On- Premise technology supported by internal staff and selected partners.

Effective staff communication and collaboration will be facilitated through an integrated communications and collaboration platform delivering core voice, video and messaging services on mobile and office based devices.

Staff have the Right IT Equipment to Work Effectively

We want our acute and community staff to have the right type of IT equipment to enable them to work effectively in a way that fits in with there daily activities and is not a barrier to their productivity or caring for patients.

This will ideally reduce the overall number of devices we need, maximizing the usage of each device through mobile enabled services. A cost effective regular rolling replacement programme will be introduced to ensure devices do not become ineffective over time.

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Mobile Connectivity for Staff, Patients & Their Families

Mobile working is key to modern working practices and we want to provide staff with the ability to work effectively wherever they need to. This will be enabled through the delivery of a secure mobile working platform providing easy remote access to digital services and information and where possible provide off-line access where connectivity is poor.

We want to make the best use of our limited office accommodation so will seek opportunities for hot-desking across our entire estate.

Patients, their relatives and careers will be provided with Wi-Fi whilst in their place of care, to access the mobile enabled services they require, either their own or ones provided by us.

Protect our Digital Infrastructure from Cyber Security Threats

Cyber security threats are on the increase year on year and protecting patient's information is a top priority for the us. As mobile working and the provision of digital services to patients increases the security systems must keep pace with the additional associated threats. The existing Cyber security policies and technology controls will be expanded to provide end to end perimeter security and proactive monitoring and alerting of suspicious events. To ensure all staff are aware of Cyber security risks there will be a rolling programme of communications and engagement activities.

System Interoperability & Information Sharing

Interoperability is the ability for systems to 'talk to each other' and transfer information in a common format. There is a need to share more information between our systems and also with external partners to provide a 360 degree view of patient's information.

We already make use of the HL7 international standard to enables the transfer of healthcare data between many existing systems. Moving forward our Electronic Patient Record will consolidate individual systems reducing the need to move information between our systems and as part of the Local Health Care Record Exemplar (LHCRE) programme, we will enable secure sharing of patient information with our regional partners.

05 Delivering the Digital Strategy

Capacity to Deliver the Digital Strategy

Planning and delivering the digital strategy requires staff with various levels of skills, expertise and experience, not just from within the Information, Management & Technology (IM&T) department but all of us as a whole, where new ideas come from or where the delivered solutions come into contact or impact staff.

We already have a high number of digital projects and programmes that are managed by a relatively small number of teams and individuals within IM&T but the level of change that clinical and operational staff are going through is significant.

As there is an increase in demand for digital innovations and solutions to help staff perform their jobs more effectively and efficiently and to improve patient care, there is more pressure and reliance on these staff to deliver them.

This strategy describes some really ambitious objectives to be delivered over the next five years, but in order to do this, we need to further invest on these key staff.

This means an increase in capacity to support the early stages of new ideas such as providing additional resource to develop business cases with each directorate, understanding and documenting clinical and operational processes and benefits, and reviewing the various suppliers and solutions on the market.

It means an increase in capacity to support the delivery of these solutions so we can do more quicker. This includes, but is not limited to, project management, business change and stakeholder engagement, end user training, technical expertise in servers, computers, networks and integration, optimisation of existing solutions and on-going system and user support.

It also means directorates being able to release their staff to own, drive and deliver the changes to working practice and the realisation of benefits.

Digital Professionals have the Right Skills and Education to Deliver the Digital Strategy

Given the complexity and significance of the digital projects and programmes that we deliver, its critical that those staff delivering it have the right skills, education and qualifications required to perform their duties to the highest standards.

We will put in place the right development pathways for these staff to ensure they have the necessary capabilities, and in turn ensure that we and our patients receive the best possible implementation of our digital solutions.

This is reinforced by the Topol Review published in 2019, that explores how technology will impact on healthcare and its workforce, focusing on the impact of digital health, genomics, robotics and artificial intelligence over the next twenty years. It highlights the need for both those delivering digital technology and those using it to have the necessary technical skills.

Service Level Agreements for Services Provided by IM&T

Our staff and our patients deserve the best level of service from its digital services in order to carry out their daily duties effectively and efficiently.

Given the level of investment we have already made and will continue make towards its digital infrastructure and solutions, we need to be sure they are operating reliably and provide the required level of performance.

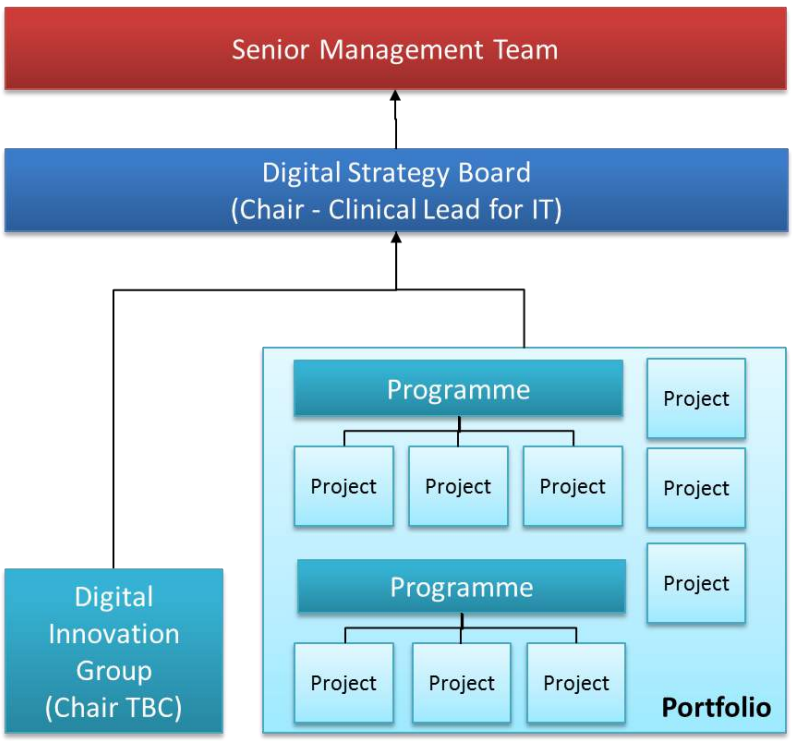
A number Key Performance Indicators (KPI's) will be developed so that staff will know what level of service to expect and be confident the overall performance meets their needs.

Governance

To successfully delivery the digital strategy there needs to be a robust governance structure in place, with clear processes and procedures.

Following a recent review, the digital governance structure has been updated to reflect our current needs. This new clinically led structure will:

- Enable ongoing development and delivery of the strategy;
- Ensure there is appropriate clinical and operational ownership of the strategy;
- Approve business cases and agree priorities;
- Support effective decision making for new ideas and their progression;
- Provide a platform for discussing business as usual issues;
- Monitor the progress of on-going project, programme and portfolio delivery;



Project Approval Process

Staff have informed us that when they have a new digital idea it is not clear how they can get this approved and progressed which can be frustrating.

A step by step approval process has started to be developed so that any member of staff, departments and directorates who have new digital ideas have a formal route for them to be considered and taken forward. This will be developed fully over time but new ideas are expected to flow through the process below.

Your Digital Strategy — Stakeholder Engagement

To ensure the digital strategy is delivered successfully, we need staff to be fully engaged. It's critical that the we deliver digital technology that meets our staff needs, that improves their everyday working life and doesn't make it worse overall. We need to be part of developing and delivering the strategy and help drive it forward.

Work has already started with the inaugural digital conference which enabled staff to contribute to this digital strategy.

Further conferences will be arranged to enable further input and to make sure we direct the strategy in the way we need it.

We will ensure that clinical and operational staff have the opportunity to be part of the delivery of our programmes and projects by inviting them to join project boards, teams, design groups and become champions of the systems/changes that are implemented and that affect them.

Overview of the HDFT Digital Strategy 2019—2024

NHS Harrogate and District NHS Foundation Trust

Delivering High Quality Care, Patient Experience and Staff Wellbeing Through Digital Transformation

Through digital working we will enable our staff to spend more of their time delivering excellent care to patients in their place of care, making their day to day lives easier, whilst ensuring they are able to communicate and collaborate more effectively and use data to learn and constantly improve the care we provide and enable patients and their carers to directly access and provide information relevant to their care.

Drivers

Harrogate & District Foundation Trust Strategy:

- To deliver high quality healthcare;
- To work with partners to deliver integrated care;
- To ensure clinical and financial sustainability;

Five Year Forward View:

- Prevent illness such as obesity, smoking and alcohol;
- Patients need greater control of their own care;
- Barriers need to be broken down between all care providers

Personalised Health and Care 2020:

- By 2020 all electronic health records would be fully interoperable so that patient records are paperless;

NHS Long Term Plan (2019):

- A new service model for the 21st century;
- Digitally-enabled care will go mainstream across the NHS;
- The future of healthcare: our vision for digital, data and technology in health and care;
- NHS staff getting the backing they need;
- More action on prevention and health inequalities;
- Taxpayers money used to maximum effect;

Themes and Objectives

Digitally Enabled and Empowered Workforce


Integrated Health Record (WebV and SystmOne)


Staff Communicating and Collaborating


Provision of Digital Technology to Enable Staff to Work Effectively Wherever They Are


Digital Transformation to Modernise Day to Day Administrative Functions


Digitally Skilled Workforce


Data and Intelligent Systems Used to Improve Decision Making, Service & Patient Safety

Digitally Connected and Informed Patients


Patients and Their Carers Directly Accessing Information and Communication Relevant to Their Care


Virtual Consultations


Patients Managing and Booking Appointments On-Line


Wearable Technology and Sharing Information with Healthcare


Remove the Reliance On Paper


Patients On-Line in their Place of Care

Future Proof and Secure Digital Infrastructure


Scalable and Reliable Access to Digital Services


Staff Have the Right IT Equipment to Work Effectively


Mobile Connectivity for Staff, Patients and Their Families


Protect Our Infrastructure from Cyber Security Threats


System Interoperability and Information Sharing

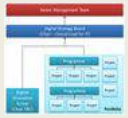
Delivery

Capacity to Deliver the Digital Strategy

Digital Professionals Have the Right Skills and Education

Service Level Agreements

Governance



Approval Process

Stakeholder Engagement

You matter most

August 2019

19

Board Committee report to the Board of Directors

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

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

1. The committee received information on the financial position in July 2019. The July position was a surplus of £326k which is broadly on plan. £30k ahead of plan. The year to date position is £46k ahead of plan.
2. The in-month key drivers for adverse variances were medical staffing, agency costs, Care Support Worker vacancies and income from Leeds activity. These pressures have been offset by a number of favourable variances across a number of directorates including a significant underspend in Children's and Countywide Community Care and a benefit from the pay award funding received from the Department of Health.
3. The CIP target for the year is £8.4m and to date CCCC and Corporate directorates have plans in place to deliver their targets. LTUC and PSC have plans totalling 84% and 85% of their targets respectively. Total plans in place total £8.9m which when risk adjusted falls to £7.4m.
4. The current forecast outturn position is behind plan. The directorate spending positions showed underspending in CCCC, a marginal overspend in Corporate with both LTUC and PSC directorates overspending. The monthly resources review meetings are taking place with directorates in which directorate pressures are reviewed in detail and actions agreed to improve the financial position.
5. Trust total activity for July was ahead of commissioned levels. The HaRD Aligned Incentive Contract is significantly over performing, whilst other contracts are under performing. For HaRD CCG, all activity types were ahead of plan.
6. Discussions are continuing with Leeds to mitigate the risks introduced by the new referral management system which has reduced the number of referrals coming through to Harrogate. This is impacting on the balance of HaRD and Leeds work being done within the Trust and on the performance of the HaRD contract.
7. The workforce position in June showed substantive staffing down by 28 whole time equivalents (wte) whilst bank and agency exceeded plan by 23 and 11 wtes respectively. Further events are planned to recruit Care Support Workers. Detailed analysis of the areas driving temporary staffing usage was presented. The Trust has breached the agency cap in the last two months and a recovery plan to stem agency costs is being developed.

8. The consolidated cash position (Trust and HIF) for July was much improved following the receipt of the 2018/19 PSF funding. Action has been taken to relieve the pressure on payments. Significant work has been done to resolve a long running dispute with NHS Property Services and agreed settlements will be made in the near future.
9. Our Use of Resources rating stands at 3 (due to the planned deficits in the early part of the year) but is forecast to be 1 at the year end.
10. The Committee received an update on commissioned contract issues, specifically the Hambleton, Richmond and Whitby GP Out of Hours contract and the North Yorkshire 0-19 services.
11. The Committee received a progress report on the development of the 5 year financial, activity and workforce plan. The first draft will be submitted to the ICS in September with the final plan due in November. The 5 year plan will need to align with HaRD CCG and reflect ICS programme requirements and capital plans. An external review of the Harrogate system is taking place and will inform future planning.
12. The Committee received a detailed report on the Trust's property portfolio with specific focus on NHS Property Services properties and the long running financial dispute. A detailed account of the current position was presented together with historic context. Significant progress has been made in resolving the issues.
13. The Committee received a report on the HDFT Digital Strategy 2019-2024. Due to time constraints the report was not discussed at the meeting. Given the Board workshop taking place on 28th August, it was agreed that all members of the Committee be asked to submit comments on the strategy to the Chief Operating Officer. A NED briefing would also be arranged prior to the strategy being presented to Board for approval.

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

- The reduction in work from Leeds and overtrade with HaRD need to be realigned to reduce the financial risk to the local system.

Matters for decision

None

Harrogate and District NHS Foundation Trust

20

Date of Meeting:	25 September 2019	**Agenda item:**	9.0
Report to:	Board of Directors		
Title:	Third Party Schedule Annual Update		
Sponsoring Director:	Mr Steve Russell, Chief Executive		
Author(s):	Mr Andrew Forsyth, Interim, Company Secretary		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** **Assurance** ✓ **Information**		
Executive Summary:	• Under the Foundation Trust Code of Governance the Board of Directors is required to maintain a schedule of the specific Third Party bodies with 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. • The scope of Third Party schedules is currently under active review nationally and it is expected that updated guidance will be available early in 2020 • It is proposed that this Third Party schedule is reviewed once the updated guidance is received.		

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

Key implications	
Risk Assessment:	None identified.
Legal / regulatory:	The 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.

You matter most

Action Required by the Board of Directors:
It is recommended that the Board of Directors: • receives and **approves** the updated Third Party Schedule as presented • **endorses** the proposal to review it again once updated guidance is received..

Third parties with roles in relation to Harrogate and District NHS Foundation Trust September 2019

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 England
- 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 Coroners (as appropriate)

- 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
- Parliamentary Select Committee on Health
- NHS Digital
- Local Authority Overview and Scrutiny Committees
- Healthwatch and Healthwatch England

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

Harrogate and District NHS Foundation Trust

21

Date of Meeting:	25 September 2019	**Agenda item:**	9.1
Report to:	The Board of Directors		
Title:	Harrogate Integrated Facilities (HIF) - Board Composition		
Sponsoring Director:	Mr Robert Harrison, Chief Operating Officer		
Author(s):	Mr Andrew Forsyth, Interim Company Secretary		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information**		
Executive Summary:	• The Board of Harrogate Healthcare Facilities Management Ltd wishes to appoint the Managing Director as Director of the Company; • The Articles of Association of the Company will require amendment to reflect more accurately the wishes of the Trust when vesting the Company; • The Trust Board, as sole Shareholder, may determine such changes to the Articles of Association.		

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

Key implications	
Risk Assessment:	None identified.
Legal / regulatory:	The Companies Act 2006 and the Articles of Association of Harrogate Healthcare Facilities Management Ltd
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified at this stage. It is proposed that an additional Director be appointed by the Shareholder; consequently any conflict of interest will be assessed at a later stage.
Reference documents:	None.
Assurance:	Not applicable.

Action Required by the Board of Directors:

It is recommended that the Board of Directors;

- **Notes** items included within the report;
- **Approves** the addition of the Managing Director to the Board of Harrogate Healthcare Facilities Management Ltd;
- **Approves** the amendment of the Articles of Association of the Company to set a maximum number of Directors;
- **Approves** the maximum number of Directors of the Company to be seven and
- **Approves** the appointment of the Chairman by the Shareholder, as one of the seven Directors to be independent of the Shareholder.

You matter most

Harrogate and District NHS Foundation Trust

Harrogate Integrated Facilities (HIF) - Board Composition

1. HIF is a wholly-owned subsidiary of Harrogate & District NHS Foundation Trust, but operates at 'Arm's Length'. When created in November 2017 it was agreed that the Board would consist of five Non-Executive Directors. The Chairman would be recruited by the Trust, two would be nominated by the Trust from the Trust Board and two would be recruited HIF. The Managing Director would not be a member of the Board.

2. The Board of HIF has recently decided to add the Managing Director as a member of the Board, as opposed to being in attendance. The Articles of Association for HIF set out in Article 20 that:

   a. The Shareholder Board (HDFT) will approve the appointment of the Shareholder Directors and
   b. Non-shareholder directors will be appointed by HIF.

3. However, the original Trust Board resolution/decision confirmed that:

   a. The HIF Board should have five Directors;
   b. That the Trust appoints an independent Chairman;
   c. That the Trust appoints two Shareholder Directors and
   d. That two Directors will be appointed by HIF.

   It was noted that the Managing Director would attend the HIF Board but would not be a member.

5. Legal advice provided to the Trust, but not known to the HIF Board, recommended that:

   a. The HIF Board should have no more than five Directors, to ensure it was agile and that the Chair had a casting vote in the event of 'deadlock'. Two Directors would be appointed by the Trust (one Executive and one Non-Executive) and three from outside the Trust.
   b. The Chair will be one of the five directors, and should be a non-Trust Director.
   c. Non-shareholder Directors would be appointed by the company
   d. The Trust would need to determine whether the Managing Director sits on the Board.
   e.

6. There is no minimum or maximum number of Directors set in the Articles of Association and the detail in the legal advice and the HDFT Board resolution is not reflected in the Articles of Association. The reserved powers for the HDFT Board do not include any additional provision in respect of Board membership or appointment. Under the Articles the Shareholder is, however, able to set a maximum number.

7. It is therefore **proposed** that:

a. The HIF Board is advised that its decision to add the Managing Director post to the Board was made in line with the Articles of Association, and is therefore accepted by the Shareholder;

The HIF Chairman should be advised by the Shareholder to ensure there is an appropriate development plan in place to support the Managing Director to perform to the expected standard of a Board Director.

8. Under company law the Shareholder(s) have the authority to amend the Articles of Association. It is **proposed** that the Trust (Shareholder) Board amends the Articles of Association at Article 20 to be aligned to the original Board resolution as follows:

i. The HIF Board to have seven Directors. This is to ensure the Chair continues to have a casting vote.
ii. The Chair, who is one of the seven Directors, will be appointed by the Shareholder and shall be independent of the Shareholder.

9. The revised Article will subsequently read:

20.1 Subject to Article 20.2, the Shareholder may at any time and from time to time by notice in writing signed on behalf of it appoint any person to be a Shareholder Director.

20.2 The Board of the Shareholder will approve all proposed appointments of Shareholder Directors in writing prior to their appointment, otherwise any appointment made without this approval is not a valid appointment of a Director.

20.3 Non-Shareholder Directors shall be appointed by the Board of Directors of the Company from time to time.

20.4. The Company Board is to have seven Directors. This is to ensure the Chair continues to have a casting vote.

20.5 The Chair, who is one of the seven Directors, will be appointed by the Shareholder and shall be independent of the Shareholder.

20.6 The Shareholder will, in addition to the Chair, appoint three Directors.

20.7 The Company will appoint a maximum of three Directors.

10. In addition Article 4.2 of the Articles of Association will need to be amended as follows:

4.2 Unless and until otherwise determined by the Shareholder, there shall be ~~no~~ **a** maximum ~~or minimum number~~ of **seven** Directors **of the Company**.

11. The Trust Board, as the Shareholder, will appoint a further, seventh, Non-Executive Director and this appointment should reflect the strategic aims of the Company.

Harrogate and District NHS Foundation Trust

Date of Meeting:	25 September 2019	**Agenda item:**	9.2
Report to:	Board of Directors		
Title:	Review of Standing Orders		
Sponsoring Director:	Mrs Angela Schofield, Chairman		
Author(s):	Mr Andrew Forsyth, Interim Company Secretary		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information**		
Executive Summary:	• Standing Orders are to be reviewed annually; • A minor change is proposed reflecting the Trust position with West Yorkshire and Harrogate ICS; • Minor changes are proposed to reflect the establishment of the Pensions Committee, the change of title of the Finance Committee to Resources Committee and of the Council of Governors' Nominations Committee to the Remuneration, Nomination and Conduct Committee.		

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:	Provide details of any legal or regulatory implications detailed in the paper. Or insert 'none identified'.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	Constitution of the Foundation Trust Articles 16.8.3 and 16.9.1.
Assurance:	Not applicable.

Action Required by the Board of Directors:

It is **recommended** that the Board of Directors:

- **Approves** the proposed amendments.

Harrogate and District NHS Foundation Trust

Standing Orders

Version	Date	Purpose of Issue/Description of Change	Review Date
1.0 2.0 3.0 4.0 5.0 6.0 7.0 8.0	Feb 2006 Feb 2009 August 2010 May 2013 August 2016 January 2017 July 2018 Sep 2019	Initial Issue Review and update Update Review and Update Review and Update Review and Update Review and Update Review and Update	Feb 2009 March 2012 August 2013 May 2016 August 2017 January 2018 July 2019 July 2020

Status	Open	
Publication Scheme	Document Library>>Policies	
FOI Classification	Release without reference to author	
Function/Activity	Standing Orders	
Record Type	Corporate documentation	
Project Name	**N/A**	
Key Words	Standing, Orders	
Standard	**N/A**	
Scope / Location	Trust-wide	
Author	Company Secretary	**Date**
Approval and/or Ratification Body	Board of Directors	25 September 2019~~July 2018~~

22

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 Constitution)* 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 A.*

These documents, together with Standing Financial Instructions, Detailed Financial Procedures, Conflicts of Interest Policy and the Anti-Fraud, Bribery and Corruption Policy 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.

CONTENTS

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

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

The Trust will also work in the context of the wider West Yorkshire and Harrogate Healthcare Partnership and the Harrogate and Rural Alliance to further this requirement.

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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 ~~b~~Board and ~~c~~Council of ~~g~~Governors in meeting their obligations to ensure that the ~~f~~Foundation ~~t~~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.

"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 ~~c~~Chief ~~f~~Finance ~~o~~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 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 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 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 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 and Conduct 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 and Social Care or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Director with responsibilities for Infection Control or Safeguarding 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 Chairman and Non-Executive Directors

The 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 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 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 Chairman for such a period, not exceeding the remainder of their term as Non-Executive Director of the Trust, as they may specify.

Paragraph 3.12 sets out the provision if the Chairman and Vice-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 Chairman in accordance with section 16.5 of the Constitution.

2.11 Powers of the Vice Chair

Where the Chairman of the Trust has ceased to hold office, or has been unable to perform duties as Chairman owing to illness, absence or any other cause, references to the Chairman shall, so long as there is no 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.

3.2 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.

3.3 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 to staff members and patients will be transacted in private. The Chairman has the power to exclude visitors on grounds of the confidential nature of the business to be transacted.

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

3.5 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 has been presented , 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.

3.6 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 ~~d~~Director, or sent electronically or by post to the agreed address of such ~~d~~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.

3.7 Lack of service of the notice on any ~~d~~Director shall not affect the validity of a meeting.

3.8 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.

3.9 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.

3.10 Setting the Agenda
The Board of Directors may determine that certain matters as a minimum shall appear on every agenda for a meeting.

3.11 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.

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

3.13 If the 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 Chairman and Vice-Chairman are absent, or are disqualified from participating, such Non-Executive Director as the ~~d~~Directors present shall choose shall preside.

3.14 Notices of Motion
A ~~d~~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.

3.15 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.

3.16 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 calendar months shall bear the signature of the ~~d~~Director who gives it and also the signature of four other D~~d~~irectors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any ~~d~~Director other than the Chairman to propose a motion to the same effect within six months.

3.17 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.

3.18 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.

3.19 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.

3.20 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 ~~d~~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.

3.21 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 ~~d~~Directors present so request.

3.22 If at least four of the ~~d~~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.

3.23 If a ~~d~~Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.24 In no circumstances may an absent ~~d~~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.

3.25 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.

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

3.27 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.

3.28 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. A record of items discussed in private will be maintained and approved by the Board of Directors.

3.29 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.

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

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

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

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

3.34 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

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

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

3.37 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).

3.38 If the Chairman or a 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 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 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 Chairman after having

consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the 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 Committees
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).

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

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;

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5.8.3 The Charitable Funds Committee

5.8.4 The Quality Committee

5.8.5 The ~~Finance~~Resources Committee

5.8.6 The Senior Management Team

5.8.7 The Pensions Committee

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.

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 ~~d~~Director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if that Board or committee shall resolve that it is confidential.

6. DECLARATIONS OF INTERESTS

6.1 Declaration of Interests - The Constitution requires members of the Board of Directors to declare interests, which are relevant and material to the Board of Directors (including membership of the WYAAT Committee in Common). All existing directors should declare such interests. Any ~~d~~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 ~~d~~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 ~~b~~Board meeting as appropriate following the change occurring. It is the obligation of the ~~d~~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 ~~d~~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 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 ~~d~~Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chairman or the Company Secretary. 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 Constitution and the Conflicts of Interest Policy.

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

7.1 Subject to the following provisions of this Standing Order, if the Chairman or a Director of the Trust has any material 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 Chairman or a Director of that Board from a meeting of that Board while any contract, proposed contract or other matter in which he has a material interest, is under consideration.

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

7.4 For the purpose of this Standing Order the Chairman or a ~~d~~Director shall be treated, subject to Standing Orders 7.2 and 7.6, as having indirectly a 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 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 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 Chairman or a Director shall not be treated as having a 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 ~~d~~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 Director:

(a) has an indirect 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 ~~d~~Director of the Trust) as it applies to a ~~d~~Director.

8. CONFLICTS OF INTEREST

8.1 Policy

Staff must comply with the 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 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 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 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 ~~d~~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 ~~d~~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 any relationship with a candidate of whose candidature that Director or officer is aware.

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 Chairman and Directors in proceedings on account of 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 appraised 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 to the Trust's Standing Orders

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 the Constitution (alongside the Council of Governors) Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any emergency decisions taken by the Chairman and Chief Executive at the next formal public meeting of the Board in accordance with SO 4.2. 5. Approve a scheme of delegation of powers from the Board to committees**.** 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. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 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. 10. Confirm the recommendations of the Trust's committees where the committees do not have the necessary powers. 11. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for charitable funds held on trust.

REFERENCE (Where applicable)		DECISIONS RESERVED TO THE BOARD
		12. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 13. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 14. Authorise and monitor use of the seal. 15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention 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. 17. Authorise the Trust to enter any joint ventures, either contractual or corporate. 18. Authorise the establishment of any subsidiary companies of the Trust.
NA	THE BOARD	**Appointments/ Dismissal** 1. Nomination of the Vice Chairman of the Trust for ratification by the Council of Governors. 2. Appoint the Senior Independent Director following consultation with the Council of Governors. 3. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 4. Appoint, appraise, discipline and dismiss the Chief Executive. 5. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 4. Approve proposals of the Remuneration and Nominations Committee regarding Directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration and Nominations Committee. 5. Ensure that appropriate succession planning is carried out for the Board and senior management team.
NA	THE BOARD	*Strategy, Plans and Budgets* 1. Define the Trust's mission, values and strategic objectives. 2. Ensure that a Board development and organisational development plans are in place to support the Trust's delivery of the strategic direction. 3. Approve proposals for ensuring quality and developing clinical governance in services provided by the

REFERENCE (Where applicable)		DECISIONS RESERVED TO THE BOARD
		Trust. 4. Approve the Trust's policies and procedures for the management of risk. 5. Approve Outline and Final Business Cases for Capital Investment, in line with financial limits defined within the Trust's Standing Financial Instructions. 6. Approve annually the Trust's operational plan, operational budget, and capital programme. 7. Approve annually Trust's proposed organisational development proposals. 8. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 9. Approve PFI proposals. 10. Approve the opening of bank accounts. 11. Approve proposals for borrowing. 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. 13. Approve proposals for action on litigation against or on behalf of the Trust.
NA	THE BOARD	**Audit** 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. 2. Receive an annual report from the Audit Committee and agree action on recommendations where appropriate of the Audit Committee. 3. Approve the appointment (and where necessary the dismissal) of internal auditors.
NA	THE BOARD	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report, Quality Report~~Account~~ and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for funds held on trust.
NA	THE BOARD	**Monitoring** 1. Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy

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REFERENCE (Where applicable)		DECISIONS RESERVED TO THE BOARD
		statements. All monitoring returns required by NHS Improvement and the Charity Commission shall be reported, at least in summary, to the Board. 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. 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.
NA	THE BOARD	**Clinical Standards and Patient Safety** 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. 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.
NA	THE BOARD	**Harrogate Healthcare Facilities Management Limited (a wholly owned subsidiary company of the Trust t/a Harrogate Integrated Facilities)** 1. Approving and signing off plans for the strategic direction of the Company. 2. Approving the Company's annual business plan. 3. Deciding whether the Company should incur expenditure outside the annual business plan which exceeds 1% of the projected budget. 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. 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. 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. 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.

REFERENCE (Where applicable)		DECISIONS RESERVED TO THE BOARD
		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. 9. Deciding whether the Company should acquire or dispose of any patent, trademark, registered design or other know-how or any intellectual property rights. 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. 11. Deciding whether to pass any resolution or take any other corporate action for the winding up of the Company. 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. 13. Deciding whether to change the Company's accounting reference period. 14. Setting the Company's accounting policies and deciding whether to change them. 15. Deciding whether the Company should acquire or agree to acquire any freehold or leasehold interest in or license over land. 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. 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.

REFERENCE (Where applicable)		DECISIONS RESERVED TO THE COUNCIL OF GOVERNORS
Constitution section 12.1		*Regulations and Control* 1. Approve the Trust's Constitution (alongside the Board of Directors). 2. Appoint, or remove, the Trust's external auditor selected from an approved list put forward by the Board of Directors. 3. Appointment, and as required removal, of the Chairman and the other Non-Executive Directors. 4. Approve appointment (by the Non-Executive Directors) of the Chief Executive. 5. Appoint the Vice Chairman of the Trust. 6. Appoint the Lead Governor ~~Deputy Chairman~~ of the Council of Governors 7. Agree decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and Non-Executive Directors 8. Approve the Trust's Membership Development Strategy. 9. Approve any merger, acquisition, separation or dissolution application in respect of the Trust before the application is made to NHS Improvement. 10. Approve the entering into of any significant transactions. 11. Approve the referral of a question by a Governor to any panel appointed by NHS Improvement 12. 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.

DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 2.1	AUDIT COMMITTEE	1. The Audit Committee will provide an independent and objective view of internal control by: (a) reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trusts activities (both clinical and non-clinical) that supports the achievements of the Trusts objectives. (b) ensuring there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards, liaises appropriately with external audit and provides appropriate, independent assurance to the Audit Committee, Chief Executive and Board. (c) reviewing the work and findings of the External Auditor appointed by the 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. 2. The Audit Committee shall be involved in the selection process when there is a proposal to review the provision of internal audit services.
SFI 2.1.3		3. The Audit Committee will receive a report from the Finance Director, at least every 5 years, on the review of banking services.
SFI 5.6.2		4. 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
		5. The Audit Committee will review the Losses & Special Payments Register on an annual basis

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFIs 9.5.2 and 9.5.3 SFI 12.2.7 SO 3.32		6. The Audit Committee will review every decision to suspend Standing Orders.
SFI 8.1.2	REMUNERATION AND NOMINATIONS COMMITTEE	1. The Remuneration and Nominations Committee will: (a) Reach decisions about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors employed by the Trust and other senior employees not on Agenda for Change terms and conditions including: (i) all aspects of salary (including any performance-related elements/bonuses); (ii) provisions for other benefits, including pensions and cars; (iii) arrangements for termination of employment and other contractual terms; (b) Ensure Executive Directors are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate; and (c) Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.
N/A	CHARITABLE FUNDS COMMITTEE	The Charitable Funds Committee has responsibility for:- 1. Overseeing development of the charity's strategy and objectives for the Charity (including the

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REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		Fundraising Strategy) for consideration by the Trust Board (corporate trustee). 2. 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. 3. 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. 4. 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. 5. Monitoring the performance of fundraising and marketing activity, ensuring that the return on investment is satisfactory and that income targets are met. 6. Overseeing the Charity's strategy, governance, major plans and key risks on behalf of the Corporate Trustee. 7. Establishing, prioritising and approving major fundraising projects. *See financial standing investments for the full list of authority levels.* 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. 9. Ensuring submission of the Annual Accounts and Trustees' report in accordance with the Charity Commission's Statement of Recommended Practice.
NA	QUALITY COMMITTEE	The Quality Committee has responsibility for: 1 Showing leadership in setting a culture of continuous improvement in delivering high quality care. 2 Overseeing preparation of the Quality Report~~Account~~ prior to approval by the Board of Directors and submission to NHS Improvement. 3 Reviewing systems, processes and outcomes* in relation to: • Delivery of the Trusts objectives in relation to quality and annual quality improvement priorities; • Quality performance and outcome measures relating to fundamental care, including the impact of cost improvement plans; • Staff metrics that impact on quality i.e. staff vacancies, statutory and mandatory training, induction, appraisal and sickness; • CQC registration and compliance with fundamental standards in acute and community services; • Organisational learning as a result of incidents, SI~~R~~Is, complaints, concerns and claims; • Organisational learning and improvement as a result of patient and staff feedback from national and local surveys including FFT, and patient safety visits;

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		• 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 DHSC arms-length bodies, regulators and professional bodies, inspections and peer reviews etc. • Research and development, quality improvement and innovation, including rapid process improvement workshops and delivery of CQUIN. 4 Receive key reports for example: • Infection prevention and control annual report; • Local Supervising Authority audit report; • Maternity screening report; • Health and Safety annual report; • Patient experience including complaints, concerns and compliments annual report; • Staff survey as it relates to the quality of care.
NA	~~FINANCE~~ RESOURCES COMMITTEE	The Resources~~Finance~~ Committee has responsibility for: 1. Supporting the Board in scrutinising financial performance and operational activity levels (excluding performance against operational standards). 2. Scrutinising the development of the Trust's financial and commercial strategy, both revenue and capital. 3. Scrutinising the assumptions and methodology used in developing the financial strategy, including activity modelling and efficiency assumptions. 4. Recommending to the Board the financial plan for submission to NHS Improvement. 5. Scrutinising and ensuring appropriate due diligence is undertaken in relation to any significant transactions as defined by NHS Improvement 6. Scrutinising the annual Cost improvement Programme and review the impact on the Trust. 7. Ensuring that annual financial plan is consistent with financial strategy. 8. Scrutinising the Trust budget prior to approval by the Board. 9. Reviewing the capital programme in line with the financial plan. 10. Reviewing activity plans in line with the financial planning assumptions. 11. Reviewing quarterly financial performance before submission to NHS Improvement 12. Assessing the impact of financial performance on the Financial Services Risk Rating 13. Overseeing implementation of service line reporting 14. Reviewing service line information, profitability of service lines and the impact of activity delivery on financial performance 15. Undertaking 'deep dive' reviews of appropriate sections of the Board Assurance Framework 16. Undertaking any relevant matter as requested by the Board of Directors

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTING OFFICER MEMORANDUM

REF	DELEGATED TO	DUTIES DELEGATED
7	CHIEF EXECUTIVE	Responsibility for the overall organisation, management and staffing of the Trust and for its procedures in financial and other matters.
8	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	• The propriety and regularity of the public finances for which he or she is answerable • The keeping of proper accounts • Prudent and economical administration in line with the principles set out in *Managing public money* • The avoidance of waste and extravagance and • The efficient and effective use of all the resources in their charge
9	CHIEF EXECUTIVE	• Signing of the accounts, accepting personal responsibility for ensuring their proper form and content as prescribed by NHS Improvement • Comply with the financial requirements of the terms of the NHS provider license • 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) • 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 • 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 • Ensure that any protected property (or interest in) is not disposed of without the consent of NHS Improvement • Ensure that conflicts of interest are avoided • Ensure that in the consideration of policy proposals relating to the expenditure, relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into

REF	DELEGATED TO	DUTIES DELEGATED
		account and brought to the attention of the Board of Directors
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 *Public Sector Internal Audit Standards*
12 & 13 (see also 14 & 15)	CHIEF EXECUTIVE	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. 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 Improvement of the position, if possible before the decision is taken or in any event before the decision is implemented, so that NHS Improvement, if it considers it appropriate, can intervene in accordance with its responsibilities under the Act.
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 Public Accounts Committee- 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 Committee'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

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REF	DELEGATED TO	DUTIES DELEGATED
		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 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 NHS FOUNDATION TRUST CODE OF GOVERNANCE

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
NHS Foundation Trust Code of Governance A.1.9	ALL BOARD MEMBERS	Subscribe to Code of Conduct.
NHS Foundation Trust Code of Governance	BOARD	Board members share corporate responsibility for all decisions of the Board.
NHS Foundation Trust Code of Governance A.1	BOARD	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: Supporting principles: 1. The Board of Directors' role is to provide entrepreneurial 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 NHS Improvement, relevant statutory requirements and contractual obligations; 3. The Board of Directors should develop and articulate a clear "vision" for the Trust. This 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. 4. The Board of Directors should set out the NHS Foundation Trust'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 Foundation Trust to meet its priorities and objectives and, then, periodically reviewing progress and management performance; 5. 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 Foundation

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		Trust and applying the principles and standards of clinical governance set out by the Department of Health, NHS England, the Care Quality Commission and other relevant NHS bodies. 6. The Board of Directors should also ensure that the NHS Foundation Trust exercises its functions effectively, efficiently and economically; and 7. The Board of Directors should set the NHS Foundation Trust's values and standards of conduct and ensure that its obligations to its members, patients and other stakeholders are understood and met.
Standing Order 2.6 (5)	CHAIRMAN	It is the Chairman's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration and Nominations Committee of the Board of Directors 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 Board of Directors; 7. appraise Non Executive Board Members in conjunction with the Council of Governors
Standing Order 2.6 (2)	CHIEF EXECUTIVE	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 fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
Standing Order 6.1	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).
3.5	CHAIRMAN	Call meetings.
3.12	CHAIRMAN	Chair all Board meetings and associated responsibilities.
3.19	CHAIRMAN	Give final ruling in questions of order, relevancy and regularity of meetings.
3.20	CHAIRMAN	Having a second or casting vote
3.29	BOARD	Suspension of Standing Orders
3.33	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.34	BOARD	***Variation or amendment of Standing Orders***
4.3	BOARD	Formal delegation of powers to committees, 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 Reservation and 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 COMPANY SECRETARY	Maintain Register(s) of Interests.
8.1	ALL STAFF	the Trust's Conflicts of Interest Policy.
8.7	ALL	Disclose relationship between self and candidate for staff appointment.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
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.

Harrogate and District NHS
NHS Foundation Trust

Board Committee report to the Board of Directors

Committee Name:	Audit Committee
Committee Chair:	Chris Thompson
Date of last meeting:	Wednesday 11th September 2019
Date of Board meeting for which this report is prepared	Wednesday 25th September 2019

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

1. **The Audit Committee undertook its regular programme of work and review during the course of the meeting. This has included reviews of the minutes of Corporate Risk Review Group and the Quality Committee.**

2. **The most recent version of the Corporate Risk Register was reviewed, with the Committee noting the most recent set of changes that had been made to the Register, confirming that the detailed analysis was consistent with the information most recently provided to the Trust Board of Directors. There was some discussion around the way in which registers are considered at Directorate level, which is generally very well done, although it was noted that further work could be done to ensure that the future minutes of the Corporate Risk Review Group include references to the progress that is being achieved in addressing risks included within the directorate risk registers. The Committee also reviewed the most recent version of the Business Assurance Framework and can confirm that it does not believe that there are any exceptional changes required to the risk scores in the Board Assurance Framework.**

3. **There was some discussion around the report of the most recent Evening Security Inspection that had been undertaken at the Hospital site. Whilst the Committee were concerned that there appeared to have been only limited progress in addressing issues raised in previous inspections, it was agreed that the forum to take responsibility for ensuring that all major issues are addressed should be the Providing a Safer Environment Group, and that the Audit Committee would monitor the progress made in this important area.**

4. **The Committee confirms that there are no matters relating to regulatory compliance to be brought to the attention of the Board**

5. **The Periodic Internal Audit Report considered at the meeting contained details of 7 audits that had been finalised during the period under review. Of these audits, one was an advisory audit that focused on improvements to internal control that had been introduced into the supplier payments area. Of the remaining 6 audits finalised, 3 had achieved a Significant Assurance outcome,**

but 3 others provided only a Limited Assurance outcome. These were:

a. **Movement of specimens**
b. **Overseas Visitors**
c. **Timely Notification of Death**

These 3 reports were discussed at length and the Committee was pleased to note that significant improvements in control should result from the agreed actions being implemented. Report (b), was particularly timely in view of the impending World Cycling Championships and the prospect of many overseas visitors to the district over the coming weeks.

6. **The Committee reviews the minutes of the PPE Group and in the past has regularly noted a lack of diligence in the preparation and submission of PPE's. It was therefore very pleased to note that good progress has been achieved by the PPE Group in raising the profile of the PPE requirements and bringing much greater rigour to this important area.**

7. **The Committee considered and noted / approved the following reports / documents:**

a. **Treasury Management Policy & Annual Report on Treasury Activity**
b. **Internal Audit Charter**
c. **Internal and External Audit Working Together Protocol**
d. **External Audit Technical Update**
e. **Fraud and Corruption Policy**
f. **Speaking Up Policy**

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

There were no new risks identified and discussed by the Committee which are to be brought to the attention of the Board.

Matters for decision

In accordance with the Constitution of the Trust, at its meeting on 2nd November 2016, the Governors recommended the appointment of KPMG as External Auditors for the Trust for a three year term of office commencing 1st December 2016, with an option to extend for a further two years, subject to satisfactory service and performance, to be reviewed on an annual basis. The Committee undertakes a full assessment of the performance of the external auditors on an annual basis. The Committee considered the performance of KPMG over the previous year at its meeting on 8th May and concluded that there were no issues of concern with the performance. However, in recognition of the fact that the finalisation of the 2018/19 year end was more protracted than had been the case in recent years, and to facilitate the discussions by the Audit Committee and Governors regarding the potential re-appointment of KPMG as external auditors for the 2019/20 year, it was agreed that the Committee would complete a further evaluation of the performance of the external auditors. This will be undertaken in advance of the next Audit Committee meeting. It was also agreed that in future, it would be more appropriate for the performance of the external auditors to be considered at the September committee meeting rather than in May.

Action Required by Board of Directors:

The Board is asked to note the considerations that took place at the meeting of the Audit Committee on the 11th September, and also the decisions taken by the Committee in respect of the re-appointment of the external auditors.

Paper 3.0

Harrogate and District NHS Foundation Trust

Council of Governors' Meeting

Minutes of the public Council of Governors' meeting held on 1 May 2019 at 18:00 hrs
at the Harrogate Masonic Hall, Station Avenue, Harrogate, HG1 5NE

Present:	Angela Schofield, Chairman Sarah Armstrong, Non-Executive Director John Batt, Public Governor Cath Clelland, Public Governor Angie Colvin, Corporate Affairs and Membership Manager Jonathan Coulter, Deputy Chief Executive/Finance Director Robert Cowans, Public Governor Clare Cressey, Stakeholder Governor Martin Dennys, Public Governor Tony Doveston, Public Governor Sue Eddleston, Public Governor Emma Edgar, Staff Governor Dr Sheila Fisher, Public Governor Andrew Forsyth, Interim Company Secretary Jill Foster, Chief Nurse Rob Harrison, Chief Operating Officer Carolyn Heaney, Stakeholder Governor Pat Jones, Public Governor Neil Lauber, Staff Governor Mikalie Lord, Staff Governor Dr Christopher Mitchell, Public Governor Laura Robson, Non-Executive Director Steve Russell, Chief Executive Dr David Scullion, Medical Director Richard Stiff, Non-Executive Director Maureen Taylor, Non-Executive Director Chris Thompson, Non-Executive Director Steve Treece, Public Governor Angela Wilkinson, Director of Workforce and Organisational Development
In attendance:	3 members of the public

1. Welcome and apologies for absence

Angela Schofield welcomed Steve Russell to his first public Council of Governors' meeting as Chief Executive.

There was a moment of silence to remember Rosemary Marsh who died suddenly in March. Rosemary was a great supporter of the NHS; she had previously held the position of Chair for the Patient Voice Group and more recently a Public Governor. She would be greatly missed.

Angela Schofield was delighted to see members of the public at the meeting and offered them a warm welcome.

Apologies were received from Dr Pam Bagley, Stakeholder Governor, Ian Barlow, Public Governor, Cllr John Mann, Stakeholder Governor, Cllr Samantha Mearns, Stakeholder Governor, Helen Stewart, Staff Governor, and Lesley Webster, Non-Executive Director.

Angela Schofield summarised the content of the meeting and looked forward to the presentation on the Strategic Plan.

2. Declarations of Interest

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

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

3. Minutes of the last meeting held on 26 January 2019

The minutes of the last meeting held on 26 January 2019 were agreed as a true and accurate record subject to further agreement of the wording at page 11, relating to the response to the question about wheelchairs.

A detailed discussion took place on the wording of the minute. There was a difference in recollection of the discussion at the meeting and it was therefore not possible to confirm the Minute. A further discussion would take place outside the meeting and it was agreed to defer confirming the full set of minutes until this wording was agreed. It was noted that the actions related to wheelchairs were reported in the supplementary Governor briefing which had been circulated.

Post Meeting Note

Minute of 26 January 2019 considered at meeting 1 May 2019 to stand:

Mrs Webster echoed Mr Coulter's comments and provided additional background confirming they were designed as porters' chairs. She acknowledged they could be difficult to manoeuvre and felt there weren't many alternatives. She assured Governors that porters would be happy to assist patients if requested and acknowledged that instruction on how to use the wheelchairs and how to seek help could be improved.

Dr Tolcher suggested that the Trust could look again at alternative models but agreed that better signage about seeking help and instructions to confirm they are meant to be pulled could be actioned.

Proposed addition to the minute:

At the meeting on the 1 May 2019 the Public Governors sought to amend the minutes to better record their recollection of the response from the Trust regarding the availability of push wheelchairs in the health sector.

The points at issue being:

1. The Trust's suggestion that push wheelchairs were not readily available.
2. A perceived reluctance of the Trust to procure push rather than pull wheelchairs for public use to assist patients, reduce the current reliance on hospital porters and as a more cost effective solution.

At the 1 May meeting a far more coherent and considered response was provided by the CEO of the Trust which was greatly appreciated by the Public Governors and served to move the matter forward in a positive manner.

4. Matters arising and review of action log

Steve Russell referred to the Governor Briefing circulated prior to the meeting which reflected an up to date position on the issues outstanding. He thanked Jill Foster, Jonathan Coulter, Rob Harrison and their teams for the work carried out to date and was happy to take further questions. The following points were confirmed in discussion:

Coffee Shop – Jonathan Coulter confirmed that a business case was being developed by HIF to include future opportunities from managing the coffee shop. The business case would be expected at an upcoming HIF Board and Governors would be kept updated.

Wheelchairs – Steve Russell confirmed that HIF would be testing a range of wheelchairs to help agree the right model/mix of wheelchairs for a rolling replacement programme.

Support for bereaved relatives – In addition to the dedicated room in main reception, Steve Russell mentioned the ongoing work taking place to improve the corridors.
Cath Clelland appreciated the update and commented on the focus to provide a better experience for patients and their families.

Ripon Community Hospital – Sue Eddleston confirmed the scaffolding had been removed that day and the entrance was now accessible. She commented that the hospital environment had improved. Angela Schofield thanked Sue Eddleston for further updates in relation to Ripon Hospital and the coffee shop.

Mikalie Lord commented briefly on wider estates issues; she did not expect a response at this meeting, but asked if there was a strategy for other properties managed by NHS Property Services going forward.

Emma Edgar thanked Steve Russell for his brief which gave clarity to outstanding issues.

Angela Schofield confirmed that Dr Ros Tolcher had dealt with the issues reported by Mr Andrew Newton regarding collecting splints.

Action:

- **Council of Governors to be kept updated on the issues noted in the supplementary briefing.**

5. Chairman's verbal update on key issues

Angela Schofield thanked Pamela Allen who had recently stepped down from her role as a Public Governor and Deputy Chair of Governors. She also thanked and offered best wishes to Dr Sheila Fisher who would be re-locating to another area and was therefore no longer eligible to continue in her role as a Public Governor for the Wetherby and Harewood area. Similarly, Helen Stewart, Staff Governor – Nursing and Midwifery would also be re-locating in June and therefore standing down from the Council. Elections would be taking place between May and July with two seats for Harrogate and surrounding villages, one seat for Wetherby and Harewood, and two seats for Staff Governors – one for Medical Practitioners and one for Nursing and Midwifery. As a consequence of Governor vacancies, membership of the Remuneration, Nominations and Conduct Committee and the Constitution Review Working Group would be reviewed.

Following the recent Care Quality Commission (CQC) inspection, Angela Schofield had made contact with the Chair of the CQC regarding the overall rating of 'Good'. There was frustration and disappointment that areas previously rated as requiring improvement had not been re-inspected therefore the overall rating could not have been upgraded to 'Outstanding'. The CQC confirmed there was nothing that could be done to amend this decision. The Trust remained extremely proud of the overall results of the inspection; staff had worked incredibly hard to ensure continuous improvement in providing the highest quality of patient care.

Regarding other recent matters, Angela Schofield was delighted to report that the Board had met with the Youth Forum on 19 March to launch their 'Hopes for Healthcare'. She also thanked the Nutritional Team for their extremely informative Medicine for Members' event in March. Governors would be asked to provide feedback for Non-Executive Directors' appraisals and they would be receiving an invite to undertake annual reviews with the Chairman.

Finally, dates coming up included the next Board to Board meeting on Wednesday 29 May, a Governor Development Session on Monday 24 June, and the Annual Members' Meeting on Wednesday, 24 July.

6. Timetable for Non-Executive Director appointments

Paper 6.0 outlined the timetable and process for the appointment of two new Non-Executive Directors to the Board.

Mikalie Lord commented on Chris Thompson's position as Director on HIF Board and asked if one of the new Non-Executive Directors would take up this role. It was confirmed that it would be for the Trust Board to discuss and nominate a replacement Director on HIF Board.

An election would be held as soon as possible to fill the two Governor vacancies on the Remuneration, Nominations and Conduct Committee in order that the Committee could progress with the recruitment process.

7. Quality Priorities 2019/20

Referring to the quality priorities for 2019/20 detailed in paper 7.0, Jill Foster summarised the content of the Quality Account. An executive summary would be produced as the document was considerably lengthy.

Laura Robson assured Governors that the Quality Report would be agreed by the Board at the end of May and was overseen by the Quality Committee. She encouraged everyone to take the opportunity to read it.

Governors supported the proposed priorities.

8. Presentation – Strategic Plan Development

Richard Stiff and Jonathan Coulter presented the development of Harrogate and District NHS Foundation Trust (HDFT) 5 year strategic plan - the slides would be made available on the Trust website at:

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

Richard Stiff summarised Governors' involvement throughout the year including continued regular updates at Council of Governors' meetings and at the Annual Members' Meeting to give the wider membership the opportunity to contribute.

It was agreed that a session dedicated to seeking Governor input into this work would be scheduled.

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

Steve Russell was pleased to be able to able to provide a brief review of 2018/19, reflect on the first four weeks in his role as Chief Executive, and then take a look at some areas of focus for the Trust in 2019/20. He recorded his thanks to all staff across the Trust for their hard work and achievements and for making him feel so welcome. He particularly wanted to thank his fellow executives for their patience and support.

Dr Sheila Foster raised a question in reference to a couple of recent issues in the national media about tooth decay and measles vaccination in areas of deprivation and asked about the reputational risk for the Trust providing children's services. She acknowledged the question was detailed and would be happy for a response at a later date.

Steve Russell confirmed there had been conversations about these issues when visiting Health Visitors; Information was available regarding the measles vaccination in North Yorkshire and it was agreed to re-visit this issue and provide a response in more detail.

Dr Sheila Foster commented on the IBR and given that the core of patient safety was good clinical care she requested that safety should be looked at in a more holistic way linked to technology and staffing. Angela Schofield agreed this would be looked at.

The slides would be made available on the Trust's website at:

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

Actions:

- **Trust response regarding measles vaccination at the next meeting.**
- **Review of IBR.**

10. Update on the Quality Committee

Laura Robson provided an overview of the Quality Committee; the primary mechanism by which the Board gains assurance regarding the safety and quality of services. Governors attended the Committee on a rota basis and more recently Laura Robson highlighted that staff would attend to provide updates on patient stories. As discussed earlier, the Committee would be monitoring the quality priorities within the Quality Report as well as receiving a wide range of detailed information in the quality dashboard.

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

Angela Schofield moved to the tabled questions submitted prior to the meeting. There were no questions from member of the public.

Emma Edgar confirmed Governors had met on 18 April and everyone had the opportunity to discuss and agree the following five questions to be submitted:

"What are the plans for IT after January 2020, beyond which time Microsoft will no longer support windows 2007? What assurances can be given in relation to impacts for staff and patients?"

Rob Harrison confirmed that the Trust was working closely with NHS Digital regarding centrally provided licences and our upgrade plan. The licences for Windows 10 were expected from NHS Digital and once received the project could be progressed.

The Trust was planning for the migration to start in June to complete around December 2020 however, this was flexible depending upon NHS Digital negotiations for Microsoft to provide Windows 7 extended support from January 2020 for a year, extending our deadline for the Windows 10 migration by 12 months.

From the total desktop and laptop estate, 15% required hardware replacement and could not be upgraded. Approximately 20% were already running Windows 10.

Chris Thompson highlighted that IT was a piece of work that internal audit would be looking at over the next year.

"What impacts are expected from new housing in the wider Trust area and how are these being planned for and is there additional funding? Are we being proactive in this with the planning authority?"

In response, Jonathan Coulter explained the funding received by the CCG based on demographics. This linked clearly to the presentation earlier and the discussions around the Strategic Plan which included assessing the impact of the growth in population. The Trust was able to input to discussions between the planning authority and the CCG and was aware of ongoing developments.

Richard Stiff also commented on the support from the Trust's internal planning team and the much wider footprint for the Trust.

"Are the Trust's efforts to attract workforce proving successful. If not, what is being done to improve the situation and is there an impact on cost and quality of care?"

Angela Wilkinson described a number of initiatives the Trust had in place to attract the best candidates to join the workforce however, there was a national shortage in some clinical areas. In addition to NHS Jobs, other methods of recruitment included overseas recruitment, social media campaigns and recruitment events. The Trust monitored all vacancies and had a recruitment plan for the coming 18 months focussed around 'hot spot' areas and forecasting recruitment needs. Angela Wilkinson agreed to circulate the plan to Governors following the meeting.

Clare Cressey asked about the consequences for the Global Health Exchange if nurses didn't go back to India after three years.

Angela Wilkinson confirmed it was each individual nurse's choice to return to India and the Trust was supportive if their choice was to stay. The Trust had had approved a business case to recruit 25 nurses through this route.

Maureen Taylor provided assurance that the Resources Committee would be receiving a regular detailed workforce report.

Steve Russell commented on the national Workforce Plan which could provide some flexibility and opportunities.

Action:

- **Circulate the recruitment plan to Governors.**

"As we move to the ICS model how do we ensure patients have a seamless service and the transfer of care between different organisations do not leave the patient without the service they need eg transport, mental health, social care?"

Following a further discussion, it was recognised that the question had not been interpreted as it was intended. It was agreed to respond to this question at the next meeting and it was felt useful to provide Governors with a briefing on the Harrogate Alliance from the new Director, Chris Watson.

Cath Clelland commented on the importance of this topic and suggested engaging with the public in a discussion at the Annual Members' Meeting.

Sue Eddleston referred to the challenges for patients requesting hospital transport which could lead to patients not attending appointments.

Actions:

- **Trust response to question at next meeting.**
- **Provide Governors with a briefing on the Harrogate Alliance.**

"In the current climate, non-disclosure agreements are becoming very topical. Can we have assurance from the Trust that these are not common place within the Trust?" Angela Wilkinson confirmed the Trust does not use non-disclosure agreements.

Angela Wilkinson confirmed the Trust does not use non-disclosure agreements.

There were no further questions**.**

12. Any other relevant business not included on the agenda

There were no other items of business

13. Member Evaluation

Angela Schofield sought views about the meeting.

It was agreed that although the meeting ran over, the time was well spent with good discussion. There was no hearing loop at the venue.

14. Close of meeting

Angela Schofield closed the meeting. She thanked everyone for attending and confirmed the next public meeting would take place on Wednesday, 7 August 2019 at 5.45 – 8.00pm (to note, the private meeting would take place at 5.15 – 5.45pm), venue to be confirmed.

NHS
Harrogate and District
NHS Foundation Trust

Date of Meeting:	25 September 2019	**Agenda item:**	9.5
Report to:	Board of Directors		
Title:	Amendment to the Trust Constitution – change of title from Deputy Chairman of the Council of Governors to Lead Governor		
Sponsoring Director:	Mrs Angela Schofield, Chairman		
Author(s):	Mr Andrew Forsyth, Interim Company Secretary		

Report Purpose:

Decision	✓	Discussion/ Consultation	✓	Assurance		Information	

Executive Summary:

- At the meeting of the Council of Governors on 1 May 2019 a proposal to amend the title of the Deputy Chairman of the Council of Governors to Lead Governor was approved *nem con*;
- The Board is required to approve changes to the Constitution of the Trust by more than half the members voting in favour.

Related Trust Objectives

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

Key implications

Risk Assessment:	None identified.
Legal / regulatory:	The Constitution of the Trust, article 11.7.1, requires the Trust to elect a Deputy Chairman of the Council of Governors from amongst the elected Governors; The Constitution of the Trust, article 27.1.1, requires more than half of the members of the Council of Governors of the Trust voting to approve amendments to the Constitution; The Constitution of the Trust, article 27.1.2, requires more than half of the members of the Board of Directors voting to approve amendments to the Constitution;
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	The Constitution of Harrogate and District NHS Foundation Trust (a Public Benefit Corporation) dated 1 August 2018

25

Action Required by the Board of Directors:
The Board of Directors is **recommended** to: • **approve** the change of title from Deputy Chairman of Governors to Lead Governor.

1. As part of a wider review of some elements of the Trust Constitution, the Constitution Review Group of the Council of Governors discussed a proposal to change the title of the Deputy Chairman of the Council of Governors to 'Lead Governor'. Whilst the current title of Deputy Chairman had been appropriate when the Trust Constitution was first agreed, and although it had not been the subject of previous discussion, it was now more usual nationally to describe the role as that of Lead Governor. This was the term recognised by NHS Providers and other external bodies, and more accurately describes the role.

2. The Review Group agreed to recommend to the Council of Governors that the title of Deputy Chairman of Governors be changed to Lead Governor.

3. At the meeting of the Council of Governors on 1 May 2019, the proposal was approved *nem con.*

4. Under the Trust Constitution, following a vote by the Council of Governors to make amendments to it, the Trust Board of Directors must approve them, again with more than half of the members of the Board voting for approval.

5. The Board of Directors is recommended to approve the change and ratify the decision of the Council of Governors.

6. In the event that the Board of Directors endorses the decision of the Council of Governors, all references in the Trust Constitution to Deputy Chairman of the Council of Governors will require amendment. These amendments would be brought to the Council of Governors for ratification at the November meeting of the Council and then brought to the Board of Directors at the November meeting for ratification.