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Harrogate and District NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS' MEETING

A meeting of Harrogate and District NHS Foundation Trust Council of Governors will take place on
Wednesday 18 May 2016 commencing at 5.45 pm
at St Aidan's Church of England High School, Oatlands Drive, Harrogate, HG2 8JR

Private discussion for Governors and the Board will commence at 5.15 pm
Members of the public are welcome to attend from 5.45 pm

AGENDA

5.45	1.0	Welcome to the public and setting the context of the meeting, including apologies for absence – *Mrs Sandra Dodson, Chairman*	
5.45	2.0	Minutes of the last meeting, 6 February 2016 – *Mrs Sandra Dodson, Chairman*	Paper 2.0
5.50	3.0	Matters arising and review of actions schedule – *Mrs Sandra Dodson, Chairman*	Paper 3.0
	3.1	Update on Quality of Care Teams, including Governors assigned to teams – *Mrs Jill Foster, Chief Nurse*	Appendix 3.1
6.00	4.0	Declaration of interests – *Mrs Sandra Dodson, Chairman*	
	4.1	Council of Governors Declaration of Interests	Paper 4.1
6.00	5.0	Chairman's verbal update on key issues – *Mrs Sandra Dodson*	
6.10	6.0	Governor sub-committees, including the following appendices – *Mrs Sandra Dodson, Chairman*	
		Appendix 6.1 - Volunteering and Education – *Mrs Jane Hedley, Public Governor*	
		Appendix 6.2 - Membership Development and Communications, – *Ms Pamela Allen, Deputy Chair of Governors/Public Governor*	
		Appendix 6.3 - Patient and Public Involvement, Learning from Patient Experience – *Mrs Joyce Purkis, Public Governor*	

		Appendix 6.4 - Quality Priorities – *Mrs Jill Foster, Chief Nurse/Ms Pamela Allen, Deputy Chair of Governors*	
6.30	7.0	Report from the Remuneration Committee, including the ratification of the Terms of Reference and Minutes, 5 May 2016 – *Ms Pamela Allen, Deputy Chair of Governors*	Paper 7.0
6.35	8.0	Communication and Marketing Strategy - *Mr Paul Widdowfield, Communications and Marketing Manager*	Presentation
6.45	9.0	Chief Executive's strategic and operational update, including Integrated Board Report – *Dr Ros Tolcher*	Presentation
7.05	10.0	BREAK	
7.15	11.0	Q&A session for members of the public and Governors	
7.45	12.0	Assurance on challenges for 2016/17 and reflection on performance 2015/16, including time for discussion – *Non-Executive Directors,*	
7.55	13.0	Approve External Auditor appointment process – *Mr Jonathan Coulter, Deputy Chief Executive/Finance Director*	Paper 13.0
7.55	14.0	Any other business	
	14.1	Annual Members' Meeting Minutes, 3 September 2015, and notification of Annual Members' Meeting, 13 September 2016 – *Mrs Sandra Dodson, Chairman*	Paper 14.1
8.00	15.0	Date and time of next meeting – **Wednesday, 3 August 2016 at 5.45 pm, venue to be confirmed**	

Harrogate and District NHS
NHS Foundation Trust

Council of Governors

Minutes of the public Council of Governors' meeting held on 6 February 2016 at 10:45 hrs at St. Aidan's Church of England High School, Oatlands Drive, Harrogate.

Present:

Mrs Sandra Dodson, Chairman
Ms Pamela Allen, Public Governor/ Deputy Chair of Council of Governors
Mr Michael Armitage, Public Governor
Dr Sally Blackburn, Public Governor
Mrs Yvonne Campbell, Staff Governor
Mrs Cath Clelland, Public Governor
Mrs Angie Colvin, Corporate Affairs and Membership Manager
Mr Jonathan Coulter, Director of Finance/Deputy Chief Executive
Dr Sarah Crawshaw, Stakeholder Governor
Mr Tony Doveston, Public Governor
Mrs Emma Edgar, Staff Governor
Cllr John Ennis, Stakeholder Governor
Mrs Beth Finch, Stakeholder Governor
Mr Andrew Forsyth, Interim Head of Corporate Affairs
Mr Robert Harrison, Chief Operating Officer
Mrs Jane Hedley, Public Governor
Mrs Pat Jones, Public Governor
Mrs Sally Margerison, Staff Governor
Mr Phillip Marshall, Director of Workforce and Organisational Development
Mr Peter Pearson, Public Governor
Mrs Joyce Purkis, Public Governor
Dr Daniel Scott, Staff Governor
Dr David Scullion, Medical Director
Mrs Maureen Taylor, Non-Executive Director
Mr Chris Thompson, Non-Executive Director
Dr Ros Tolcher, Chief Executive
Mrs Lesley Webster, Non-Executive Director

In attendance: 4 members of the public

1. Welcome to the newly elected and appointed Governors, the public and setting the context of the meeting, including apologies for absence

Apologies were received from Cllr. Bernard Bateman, Stakeholder Governor, Ms Clare Cressey, Staff Governor, Mrs Liz Dean, Public Governor, Mrs Jill Foster, Chief Nurse, Mr Neil McLean, Non-Executive Director, Mrs Zoe Metcalfe, Public Governor, Mrs Joanna Parker, Stakeholder Governor, Prof. Sue Proctor, Non-Executive

Director, Mr Andy Robertson, Public Governor, Mr Ian Ward, Non-Executive Director, Mr Paul Widdowfield, Communications and Marketing Manager and Dr Jim Woods, Stakeholder Governor.

Mrs Dodson offered a warm welcome to the members of the public and to the newly elected and appointed Governors in attendance: Mrs Campbell, Staff Governor for Non-Clinical, Mr Doveston, Public Governor for Harrogate and surrounding villages and Mrs Finch, Stakeholder Governor representing the Voluntary Sector. New Governors Ms Cressey, Staff Governor for Other Clinical and Mrs Metcalfe, Public Governor for Knaresborough and east district, were unable to attend the meeting due to other commitments. Mrs Dodson also congratulated Dr Scott, Staff Governor for Medical Practitioners on being re-elected for a second term of office.

Mrs Dodson commented that some members of staff would be using BoardPad during the meeting; an electronic meeting and document system as opposed to hard copy papers. She welcomed questions for item 9 on the agenda and asked for these to be submitted during the break.

2. Minutes of the last meeting, 4 November 2015

The minutes of the last meeting were agreed as a true and accurate record.

3. Matters arising and review of actions schedule

3.1 Appointment of Company Secretary

Mrs Dodson was pleased to report that the Trust had appointed Miss Debbie Henderson as the Trust's Company Secretary; this role was a professional and qualified position to develop further the Deputy Director of Corporate Affairs role. Miss Henderson was already established in this role at University Hospitals Bristol.

Mrs Dodson took this opportunity to thank Mr Forsyth who had covered the role of Deputy Director of Corporate Affairs brilliantly in the interim measure and he would continue to work for the Trust as Revalidation and Compliance Manager. Mr Forsyth had been recently acknowledged by the Care Quality Commission (CQC) for his input into the organisation of their recent visit to the Trust.

3.2 Effectiveness of Quality of Care Teams update

In Mrs Foster's absence, Mrs Dodson provided a brief explanation of the role of the Quality of Care Teams for those members of the public present.

There had been some areas of concern expressed by Governors regarding both the consistency and medical representation across the different teams. Mrs Foster was leading a review into the effectiveness of the Quality of Care Teams including a review of standards which would form the basis of the overall Terms of Reference. There would be reference to the Trust's objectives and quality improvement priorities in the standards going forward.

Mrs Dodson confirmed that Mrs Colvin would continue to assign Governors to a variety of Quality of Care Teams across the Trust and she highlighted how their attendance at these meetings would provide Governors with an additional level of assurance into quality of care.

Good quality care is at the heart of the Trust's vision and mission and Dr Tolcher stated that the Quality of Care Teams would assist in the delivery of our Quality Charter.

Matters arising not on the agenda:

Mr Pearson asked for an update on the Ripon development.

Dr Tolcher confirmed that work was progressing, albeit slowly. No final decisions had been made as scoping work was still underway, but hopefully there would be a further update available at the next meeting in May.

Mrs Clelland enquired about the contract to deliver children's services in Middlesbrough; further information would be available in the Chief Executive's update under item 8 on the agenda.

Mrs Jones raised an issue regarding patients being treated at York Hospital or via a private appointment as there were no appointments for some specialities through Choose and Book at Harrogate for the foreseeable future. Mrs Dodson commented that a similar question regarding Choose and Book had been raised by a Governor at a previous meeting.

In response, Mr Harrison confirmed that the Trust continued to work hard to predict the demand for the range of services using the NHS e-Referral Service, a national programme which had replaced Choose and Book in 2015. The system worked well where capacity matched demand however, when demand was high, some specialities ran out of slots available to book online. Mr Harrison was unable to discuss individual cases, but agreed to follow this up with Mrs Jones outside of the meeting.

Action: Mr Harrison/Mrs Jones

Mrs Dodson clarified that individual cases could not be discussed in the meeting, but thanked Governors for raising subjects which were in the interests of the members and the general public, and of a generic matter.

Mr Pearson asked for an update regarding District Nursing in the Ripon area following the question he raised at the last meeting in November.

Dr Tolcher confirmed that the first New Care Model pilot site in Knaresborough, Boroughbridge and Green Hammerton commenced on 1 February. District Nurses were now working together to deliver a joined up service; recruitment had been successful and the situation had improved. Staff were able to choose their own shift pattern and the view was that caseloads were appropriate.

There were no other outstanding actions on the schedule at Paper 3.0.

4. Declaration of interests

There were no declarations of interests received.

4.1 Council of Governors' Declaration of Interests

Mrs Dodson reminded Governors that they would be asked to sign a Declaration of Interest form on an annual basis and the overall summary would be brought to each quarterly Council of Governor meeting as a standard item on the agenda. Governors were reminded that it was the obligation of each individual Governor to inform the Trust in writing within seven days of becoming aware of the existence of a relevant or material interest.

5. Chairman's verbal update on key issues

Mrs Dodson was pleased that Ms Allen was now at the meeting in her role as Deputy Chair of Governors and Lead Governor. She was looking forward to working with Ms Allen who had already shown her enthusiasm and commitment to the role.

Mrs Dodson referred briefly to the CQC inspection which took place between 2 and 5 February; a further update would be included in the Chief Executive's update later in the meeting.

6. Governor sub-committees

Mrs Dodson clarified the role of the two formal sub committees and the Patient and Public Involvement, Learning from Patient Experience Group and thanked Governors for their commitment and involvement.

6.1 Volunteering and Education

The report from the Volunteering and Education Governor Working Group, chaired by Mrs Jane Hedley, had been circulated prior to the meeting and was taken as read.

Mrs Hedley highlighted the ongoing activities of committed volunteers including success at the 2015 Harrogate and District Volunteering Oscars. She was also delighted to provide an update regarding the Work Experience Programme, which was being run in-house by the Corporate Secretarial team. Contact had been made with 16 local schools and there was an increase in the total number of placements being offered. Mrs Hedley thanked the team for their hard work in raising the profile of such a valuable programme.

There were no questions for Mrs Hedley.

Mrs Dodson added how proud the Trust was of all the volunteers who were dedicated to giving their time to improve the patient experience.

6.2 Membership Development and Communications

The report from the Membership Development and Communications Governor Working Group, chaired by Ms Allen, had been circulated prior to the meeting and was taken as read.

Ms Allen highlighted the Foundation News magazine in her report and was looking forward to the next edition which would be sent to members shortly. She asked for fellow Governors to volunteer in the production of the magazine by proof reading articles; anyone interested in helping should contact Mrs Colvin following the meeting.

There were no questions for Ms Allen.

6.3 Patient and Public Involvement

The report from Mrs Purkis, on the last meeting of the Learning from Patient Experience Group, had been circulated prior to the meeting and was taken as read.

Mrs Purkis explained that the Group met every month and the meeting was chaired by the Chief Nurse, Mrs Foster. She highlighted the National Inpatient Survey in her report and confirmed that, at their last meeting, the Group had agreed to select five questions from the survey for review at Directorate level.

Mrs Dodson reiterated the importance of the Group and how their role was to understand, monitor and challenge live issues and to seek to improve the quality of experience for people using Trust services.

There were no questions for Mrs Purkis.

6.4 Patient Safety Visits – update on last year and plans for this year

The report from the Deputy Director of Governance had been circulated prior to the meeting and taken as read.

Mrs Dodson provided a brief explanation of Patient Safety Visits and referred to the report which included a detailed summary of visits made in the last year, issues raised, and plans for the year ahead. Mrs Dodson was pleased that Governors had also taken part in a significant number of visits alongside Executive and Non-Executive Directors.

Cllr. Ennis commented that it was good to see a summary of the visits undertaken however, following a visit to Ripon Fast Response Team, he would have liked to have seen the visit report. Dr Tolcher apologised for this oversight and provided reassurance that following each visit a written report and action log was produced. She also confirmed that Senior Management Team received a progress report on Patient Safety Visits. It was agreed to circulate the Ripon Fast Response Team visit report to Cllr Ennis and circulate the appendices referred to in the paper.

Action: Deputy Director of Governance

7. HDFT Constitution and ratification of the minutes of the HDFT Constitution Review Working Group, 07.12.15

Paper 7.0 had been circulated prior to the meeting and taken as read. The Council of Governors was asked to discuss and approve the proposed amendments to the Constitution and ratify the minutes of the Constitution Review Working Group, 7 December 2015.

Mrs Dodson asked for any questions and explained that the following the meeting, the proposed amendments would be submitted for discussion and approval to the Trust's Board of Directors at its meeting on 24 February. If approved, the amended Constitution would then be submitted to Monitor and the vacancy for a Public Governor for the Rest of England would be included in the scheduled election in the spring.

In line with the proposed amendments:

1. Following the recent appointment of a 'Company Secretary' the term 'Secretary' and 'Deputy Director of Corporate Affairs' would be replaced with 'Company Secretary' throughout the document – **all Governors present at the meeting agreed.**

2. To increase the number of public constituencies to six and increase the Council of Governors by one additional public Governor to represent the interests of a membership covering 'The Rest of England' – Mrs Dodson summarised the detailed discussion regarding these proposals by the Constitution Review Working Group and welcomed any Governors present at the Working Group to answer any questions.

   Mrs Crawshaw commented that the Trust could have interest in 'The Rest of England' vacancy from someone residing in the South of England; although this would probably be unlikely.

   Mrs Clelland asked for some assurance that the Trust would not go to disproportionate effort to obtain high numbers of members in 'The Rest of England'. Mrs Dodson confirmed that the Group had discussed this and agreed that a minimum of 50 members would be required.

   Mrs Colvin explained that we had approximately 455 Affiliates on our database at the current time; people who had chosen to engage with the Trust but were unable to become members as they were either under the age of 16 or lived outside of the Trust's membership catchment area. The people 16 years or over residing in England would therefore automatically become members and would be the target audience for the new 'Rest of England' Governor.

   In view of the addition of nearly 500 new staff members with the new contracts for Children's Services in Middlesbrough, Durham and Darlington, Mrs Margerison asked about the addition of another Staff Governor.

   In response, Mrs Dodson confirmed that as the majority of additional staff would fall within the Nursing and Midwifery Staff Class and, as there were currently two

Staff Governors to represent the interests of these members, the numbers across the four classes remained proportionate and the Working Group agreed there was not a requirement at this stage to review further.

Dr Scott also added that this extra constituency would impact positively on future recruitment of Non-Executive Directors as applicants were required to be a member of the Trust.

Mrs Dodson thanked Dr Scott for highlighting this and confirmed that we would want to consider recruiting Non-Executive Directors who resided in areas where we were offering services.

In relation to the proposed amendments listed in Paper 7.0, items 2 – 4, all Governors present at the meeting agreed.

Finally, Mrs Dodson confirmed that item 5 did not require a vote, but for clarity, the Working Group agreed with the proposal to retain a Vice Chairman on the Board as the Council of Governors had a Deputy Chairman; the Constitution at section 16.5 would therefore not be amended.

The proposed amendments would now be submitted for discussion and approval to the Trust's Board of Directors on 24 February.

Action: Mr Forsyth

8. Update from the Chief Executive, including the Integrated Board Report

Dr Tolcher's paper summarised the key strategic matters impacting on the Trust at present and an update on operational and quality performance was circulated with the Integrated Board Report prior to the meeting and taken as read.

Operational performance and quality

Dr Tolcher was pleased to report that the Trust continued to perform well against all the national performance standards including access and waiting times, referral to treatment time targets and emergency department access targets.

Moving on to an overview of the financial position, the Trust had reported a small loss in December 2015 however the forecast was to deliver a small surplus at the end of the financial year. Key drivers of overspend continued to be ward nursing and medical staffing but the Trust continued to work hard and monitor staffing levels carefully to ensure quality and safe patient care.

Dr Tolcher was thrilled to report that the Trust had spread its footprint and would provide children's services in Durham, Darlington and Middlesbrough from 1 April. Approximately 500 new staff would join the Trust and there were a variety of plans in place to engage and communicate with our new colleagues.

Strategic matters

Dr Tolcher confirmed the Trust had been busy with the Operational Plan covering the next 12 months; the first draft was to be submitted to Monitor the following week. In addition to this document, the Trust was also working with partners to submit a five year Sustainability and Transformation Plan (STP) by the end of June.

Dr Tolcher described 'transformation footprints' or 'place'; an agreement between health and social care to work together. Conversations were underway as the Trust would be part of a number of 'places' due to overlap of service provision across Leeds, York, North Yorkshire and now Durham, Darlington and Middlesbrough.

Dr Tolcher went on to explain the government's Sustainability and Transformation funding allocated to individual acute providers. The NHS was heading for a deficit of around £2.8 - £3 billion and the aim of the government funding was to ensure that the provider sector returned to financial balance over the next 12 months.

The Trust had been allocated £4.6 million for 2016/17, but there would be rules attached, for example: agreeing to deliver a surplus of £6.8 million (an additional £2.2 million savings in addition to the £4.6 million cash allocated), continuing to deliver access standards in relation to referral to treatment 18 week target, A&E target, ambulance waits and compliance with Agency Cap rules. Dr Tolcher explained this was similar to having savings in the bank that could not be touched for 12 months. Further information was awaited on when the controls would be relaxed and when the Trust could re-invest the £4.6 million.

At this stage in the meeting Dr Tolcher invited Governors to ask questions about any of the items discussed.

Mrs Clelland commented that there was no certainty at this stage that the funding controls would be relaxed after 12 months.

Dr Tolcher confirmed this had not been clarified and the finer detail was still unknown at this stage. Mr Coulter added that it was a 'no lose' situation as the Trust would plan to deliver a surplus of £2.2 million, and if this was achieved the £4.6 million would be in the bank. He added that other Trusts had been asked to save more in order to receive the additional funding.

Mrs Edgar asked how we envisaged achieving the required surplus when we were behind plan.

Mr Coulter agreed this was a challenge however the Agency Cap, collaborative working and robust cost improvement plans would all have an impact and as yet there was still uncertainty about the exact rules on receiving the funding.

Mr Armitage asked for clarity on the government funding and Mr Coulter confirmed that the Trust would need to have a £2.2 million surplus at the end of the financial year 2017 in order to get the £4.6 million for future investment; this would be for us to decide how to spend it, but the final rules were awaited.

Mr Armitage added that if the Trust was behind plan in December he assumed it was also behind plan in January and asked if we were hopeful of a break-even position at the end of the financial year. Mr Coulter was pleased to report that historically there was always an increase in the activity level in the last quarter of the financial year and this would have a positive impact on the financial balance.

Mrs Clelland raised the question about a number of community service contracts being due for re-negotiation and asked if the Trust was confident these services would remain with the Trust.

Mr Coulter confirmed that in 2016/17 there were a number of community service contracts up for renewal, eg Podiatry and Wheelchair Services and the Trust was currently undergoing a review to assess services and a re-tendering process. He added that most contract renewals would be due in 2017/18.

Dr Tolcher continued with her update at this stage.

Governance and assurance

The Trust was required to submit a quarterly Governance Statement to Monitor and the Board of Directors had approved a 'Green' rating for Quarter 3.

Dr Tolcher highlighted that Foundation Trusts were required to undertake an external assessment of the competency and skills of the Board in the form of a Well Led Review every three years, within the terms of their licence. The Trust commissioned Deloitte to undertake this robust review which included observations and interviews to understand the governance of the organisation, its systems and processes. The final report had been received at the end of December which provided assurance that the Trust was well led and offered key findings for areas of development (these could be found in Paper 8.0 in more detail). Dr Tolcher was delighted to report feedback from Deloitte that suggestions for further development was the smallest they had ever provided across the Trusts they had worked for.

Mrs Webster added that the Quality Committee would look at the findings from the Well Led Review and she would be happy to provide feedback at the next meeting.

Action: Mrs Webster

Finally, Dr Tolcher provided a verbal update on the CQC inspection. She confirmed that in the previous week a total of 61 inspectors had visited our sites far and wide meeting with staff and patients and their families. Feedback from the Chair and Lead Manager from the CQC was that they were very impressed with the staff who were positive, welcoming and open and honest in their conversations. They were also pleased with the number of comments received from service users and stated that they had received over 600 comment cards, most of which were overwhelmingly positive, and this was in fact the most ever received by the CQC. Dr Tolcher confirmed that the CQC would now look at key areas and triangulate their data which would involve a huge amount of information gathering. It was hoped that the Trust would receive a final rating within the next 6-8 weeks.

On behalf of the Board, Mrs Dodson wished to formally thank colleagues and pay tribute to the professionalism of all staff involved. She also thanked the Executive Team who had led the organisation of the CQC visit.

Mrs Edgar talked about the staff experience during the CQC inspection and for some this had brought about a level of anxiety. She had attended two discussion sessions with inspectors; one in her role as a Staff Governor with fellow Governors and the other as a Specialist Nurse along with Senior Nurses, Ward Managers and Matrons.

She confirmed good attendance by staff during a busy working day and reported that colleagues enjoyed the opportunity to talk to inspectors about high quality care, feeling well led with accessible leaders and working for a friendly organisation. She expressed the feeling that everyone spoke as 'one' and this was a positive and emotional experience.

Mrs Dodson thanked Mrs Edgar for sharing this with her fellow Governors and added that the Chair of Inspectors had commented that the Trust 'felt like a family'.

9. Q&A session for members of the public and Governors

Mr Elliot, member of the public, complimented Dr Tolcher on her report and asked if the external review carried out by Deloitte was value for money.

Mrs Dodson clarified that Foundation Trusts were required to seek third party assurance in the form of a Well Led Review every three years within the terms of their licence.

Dr Tolcher summarised the selection process which included inviting bids from various companies to undertake the work. The Trust interviewed three companies and their overall costs were similar. The Trust felt that Deloitte had the most appropriate expertise and experience and were able to provide a wealth of evidence from work undertaken with other Trusts. The cost of the review was approximately £35-40k which included the initial review and then some follow up work afterwards for example supporting the Quality Committee. Dr Tolcher confirmed that the Trust received value for money as Deloitte were able to provide additional information to the Trust.

The external assessment process complimented the role of the Council of Governors as a third party gaining assurance and confidence in the processes and systems in place. Governors could take assurance from the review findings as well as the Executive Team.

Ms Allen added that she was interviewed by Deloitte and she was impressed with the level of questioning; she could evidence how Governors' opinions were valued and how the Council was integrated into the governance of the organisation.

Mrs Dodson confirmed that Rev Dr Willshaw was also interviewed by Deloitte as he was the Deputy Chair of Governors and Lead Governor up to the end of December 2015. She endorsed Dr Tolcher's comment that the work was value for money however going forward it was hoped that a pool of expertise from peer Trusts could be developed to undertake the exercise.

Dr Scullion reiterated the reputational benefits of an organisation that was well led.

Ms Paulak, member of the public, wished to comment that she had received the finest treatment in the organisation, but asked whose responsibility it was to check a patient's GP details.

Mr Harrison confirmed he could not discuss individual matters in the meeting, but confirmed there were several ways in which a patient's GP details could be checked

against what was held on Trust patient records. He confirmed that both the receptionist and the medical staff would usually ask the patient to clarify their GP details when they arrived at clinic or for treatment. He also confirmed that where IT systems were connected, GP details should match. Mr Harrison agreed to communicate a reminder to all staff of the importance of asking for GP details as part of the patient pathway.

Action: Mr Harrison

Mrs Clelland, Public Governor, asked for an update on Junior Doctors and whether any local issues had emerged.

Mr Marshall confirmed that the junior doctors' industrial action was a national issue around their new contract of employment. A second period of industrial action was due to take place on 10 February. Essentially, Junior Doctor cover would be similar to Christmas Day, providing emergency care only between 8 am 10 February until 8 am the following day. Mr Marshall confirmed a significant amount of work had gone into preparations for the industrial action to ensure that the Trust continued to be well prepared and that high quality patient care remained the primary focus. The Trust hoped to keep disruption to patients to an absolute minimum and remained committed to working with and supporting Junior Doctors during this difficult time.

Mr Marshall also informed Governors about a recent visit from Health Education England following some concerns raised about education and training for Junior Doctors. An action plan had been received from the visiting team and the Deanery was working with us on the intensity of work for the Junior Doctors.

10. Non-Executive Directors update including time for discussion

10.1 Update on involvement in the Annual Plan for 2016/17 and views on the progress of Non-Executive Director 360 degree feedback

Mrs Taylor, Chair of the Finance Committee, confirmed the Committee had met to consider the draft Operational Plan prior to submission to Monitor. She confirmed that Governors met periodically and received regular updates on the Operational Plan. She provided a brief explanation of the format of both the Operational Plan and the new five year Sustainability and Transformation Plan and explained the role of the Committee was to scrutinise and have oversight of the development and delivery of the financial plan. To conclude, Mrs Taylor assured Governors that the Finance Committee was happy with the draft Operational Plan.

Mr Thompson highlighted the work of the Business Development Team to develop innovative ideas and bring new business to the Trust. He was happy to confirm that Non-Executive Directors were confident in the Trust's process to bid for new business.

On behalf of the Council of Governors, Dr Scott was pleased with the Governor involvement in the Operational Planning process. He asked for an update on plans in the coming year for seven day working.

Dr Scullion confirmed that Emergency Department Consultants routinely worked weekends as well as Radiologists and Physicians; other medical

services were also provided on weekends such as MRI scans. He confirmed the Trust was close to appointing another Consultant Surgeon and there was lots happening to focus on a seven day emergency service.

Mr Doveston added that the Yorkshire Air Ambulance accessed four trauma areas with 24 hour per day service.

Mrs Dodson provided an update on the progress of the Non-Executive Director 360 degree feedback; a pilot commissioned by Health Education Yorkshire and the Humber to develop an innovative 360 degree feedback approach to support leadership development for Non-Executive Directors. Mrs Dodson commented that the framework methodology provided a valuable way to look at both individual and collective performance and all Non-Executive Directors were currently undergoing conversations with Executive Directors, Clinical Directors and Governors regarding their role and responsibilities. Mrs Dodson thanked Governors for their involvement in the pilot.

Mr Thompson reflected on the timing of the pilot and stated it was well timed with the Well Led Review and assisted in the preparation for the CQC. He welcomed honest feedback from colleagues and believed that the process was already having a positive impact on the Board. He highlighted the professionalism of the coaches and expressed his delight in the way in which the local NHS was leading the way with such an innovative approach.

Mrs Taylor echoed Mr Thompson's comments and confirmed this process was better than a predominantly paper-based one she had been involved with before. She explained how discussions were based around a scenario and focussed on feedback around contribution and actions for improvement. She agreed that the input from the coaches had formed a positive part of the process.

Mrs Edgar said she found her one to one with Mrs Webster a valuable exercise and it gave them the opportunity to get to know each other better.

Mrs Dodson hoped that the pilot would be rolled out nationally as Non-Executive Directors welcomed personal development similarly to any other members of staff in the organisation. Further analysis and evaluation was required to determine how often this feedback was required.

Mrs Dodson asked if there were any further questions for Non-Executive Directors before she moved to the final item on the agenda.

Mrs Margerison asked about Non-Executive Director involvement in the Harrogate Health Transformation Board.

Mrs Dodson confirmed that Non-Executive Directors were kept well informed via Dr Tolcher's updates and minutes following Board meetings.

Mrs Webster confirmed it was important to be kept appraised and described how the information was fed into both the Finance and Quality Committees.

There were no more questions for Non-Executive Directors and Mrs Dodson moved on to any other business.

11. Any other business

Mrs Colvin confirmed the next Governor meeting to discuss the Operational Plan would take place on 22 February and details would be circulated.

Mrs Dodson raised awareness of the Trust's staff pantomime, 'Dr Al Addin and the Missing Medicines', taking place at the Frazer Theatre, Knaresborough from 24 – 27 February. All proceeds would go to the Harrogate Hospital and Community Charity.

12. Date and time of next meeting

Mrs Dodson thanked everyone for attending and confirmed the next meeting would take place on Wednesday, 18 May 2016 at 5.45 pm at St. Aidan's High School in Harrogate.

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Harrogate and District NHS
NHS Foundation Trust

HDFT Council of Governor Meeting Actions Schedule – May 2016
Completed Actions

This document logs actions completed following agreement at Council of Governor meetings. Completed items will remain on the schedule for the following three meetings and then removed.

Outstanding items for action are recorded on the 'outstanding actions' document.

Ref	Meeting Date	Item Description	Director/Manager Responsible	Date due to go to Council of Governor meeting or when a confirmation of completion/progress update is required	Confirm action complete or detail progress and when item to return to Board if required
1	29 July 2015	Circulate dates of future Quality Committee meetings to Governors	Mrs Angie Colvin, Corporate Affairs and Membership Manager		Complete
2	29 July 2015	Circulate copy of the Non-Executive Directors' updated objectives to Governors	Mrs Angie Colvin, Corporate Affairs and Membership Manager		Complete
3	4 November 2015	Contact H&RCVS re Stakeholder Governor	Mrs Sandra Dodson, Chairman		Complete

4	4 November 2015	Consider adding Trust objectives and quality improvement priorities to Quality of Care Team Terms of Reference and agenda templates	Dr Sylvia Wood, Deputy Director of Governance		Complete
5	6 February 2016	Circulate Ripon Fast Response Team visit report to Cllr Ennis and missing appendices from paper	Dr Sylvia Wood, Deputy Director of Governance		Complete
6	6 February 2016	Amended HDFT Constitution to be submitted for discussion and approval to Board of Directors 24 February	Mr Andrew Forsyth, Interim Head of Corporate Affairs		Complete
7	6 February 2016	Reminder communication to staff re collecting GP details from patients attending appointments	Mr Rob Harrison, Chief Operating Officer		Complete

Harrogate and District NHS
NHS Foundation Trust

HDFT Council of Governor Meeting Actions Schedule – Outstanding Actions

This document logs items agreed at Council of Governor meetings that require action following the meeting. Where necessary, items will be carried forward onto the Council of Governor agenda in the relevant agreed month. The Director/Manager responsible for the action will be asked to confirm completion of actions or give a progress update at the following Council of Governor meeting when they do not appear on a future agenda.

When items have been completed they will be marked as such and transferred to the completed actions schedule as evidence.

Ref	Meeting Date	Item Description	Director/Manager Responsible	Date due to go to Council of Governor meeting or when a confirmation of completion/progress update is required	Detail progress and when item to return to Council of Governor meeting if required
1	16 October 2013	Invite Governors to Consultant Interview Presentations	Mrs Angie Colvin, Corporate Affairs and Membership Manager	Ongoing	Ongoing
2	29 October 2014	Elected Governors to receive regular updates on the Healthy Ripon project	Chief Executive update	Ongoing	Ongoing
3	29 July 2015	Update on progress of Nutritional Assistants	Mrs Jill Foster, Chief Nurse	18 May 2016	
4	4 November 2015	Update on the effectiveness of Quality of Care Teams	Mrs Jill Foster, Chief Nurse	6 February 2016 Further update 18 May 2016	
5	6 February 2016	Provide feedback from Quality Committee on findings from Well Led Review	Mrs Webster, Non-Executive Director	18 May 2016	

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Appendix 3.1

Harrogate and District NHS
NHS Foundation Trust

Governors assigned to Quality of Care Teams – updated May 2016

Governor	Quality of Care Team
Pamela Allen, Public Governor	Littondale/Nidderdale
Michael Armitage, Public Governor	Critical Care
Bernard Bateman, Stakeholder Governor	Wensleydale/Swaledale (in progress)
Sally Blackburn, Public Governor	Joint Health Visitor and School Nursing, Harrogate
Liz Dean, Public Governor	Lascelles Rehabilitation Unit
Tony Doveston, Public Governor	Sir Robert Ogden Macmillan Centre
John Ennis, Stakeholder Governor	GP Out of Hours (in progress)
Pat Jones, Public Governor	Paediatrics
Zoe Metcalfe, Public Governor	Ripon Community Hospital (in progress)
Peter Pearson, Public Governor	Pathology
Joyce Purkis, Public Governor	Emergency Department

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Harrogate and District NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS
DECLARATION OF INTERESTS

The following is the current register of the Council of Governors of Harrogate and District NHS Foundation Trust and their declared interests.

The register is maintained by the Foundation Trust Office, and holds the original signed declaration forms. These are available for inspection by contacting the office on 01423 554489.

Name	Governor Status	Interests Declared	
Ms Pamela Allen	Public elected	NONE	
Mr Michael Armitage	Public elected	NONE	
Cllr Bernard Bateman	Stakeholder	**Directorships, including non-executive directorships held in private companies or PLCs**	Chairman – The Think Tank (Bulb Ltd) Chairman – Oakmore Investments
		A position of Authority in a charity or voluntary organisation in the field of health and social care	President of AGE UK North Yorkshire President of Ripon YMCA
		A position of Authority in a local council or Local Authority	Chairman and County Councillor North Yorkshire County Council Councillor on Harrogate Borough Council Member of Ripon City Council.
		Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	President of AGE UK North Yorkshire
Dr Sally Blackburn	Public elected	NONE	
Mrs Yvonne Campbell	Staff elected	NONE	

Name	Governor Status	Interests Declared	
Mrs Cath Clelland	Public elected	**Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).**	Canny Consultants Ltd, Director and part owner York St John University Board of Governors
Dr Sarah Crawshaw	Stakeholder	**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**	National Institute for Health Research Clinical Research Network (NIHR CRN)
Ms Clare Cressey	Staff elected	NONE	
Mrs Liz Dean	Public elected	NONE	
Mr Tony Doveston	Public Elected	**A position of Authority in a charity or voluntary organisation in the field of health and social care**	Volunteer for Yorkshire Air Ambulance
Mrs Emma Edgar	Staff elected	NONE	
Cllr John Ennis	Stakeholder	**Position of Authority in a local council or Local Authority**	Cllr Harrogate Borough Council Cllr North Yorkshire County Council
Mrs Beth Finch	Stakeholder	**A position of Authority in a charity or voluntary organisation in the field of health and social care** **Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services**	Operational Senior Service Manager, British Red Cross Independent living (Yorkshire Area) Operational Senior Service Manager, British Red Cross Independent Living (Yorkshire Area)
Mrs Jane Hedley	Public elected	NONE	
Mrs Pat Jones	Public elected	**Position of authority in a local council or Local Authority** **Position of authority in a charity or voluntary organisation in health and social care**	Conservative Councillor representing Stray Ward Welcome to Harrogate Board Member Trustee at Harrogate CVS Governor at Harrogate Ladies College Trustee at Harrogate International Festival

Name	Governor Status	Interests Declared	
Mrs Sally Margerison	Staff elected	NONE	
Mrs Zoe Metcalfe	Staff elected	**Position of authority in a local council or Local Authority**	Harrogate Borough Councillor
Mrs Joanna Parker	Stakeholder	**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**	Employee at York Teaching Hospital NHS Foundation Trust.
Mr Peter Pearson	Public elected	**Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies)** **Position of authority in a local council or Local Authority**	Director – Severn Valley Railway (Holdings) PLC Conservative Councillor representing Spa Ward, Ripon City Council.
Mrs Joyce Purkis	Public elected	**Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services**	Volunteer at St Michael's Hospice, Harrogate
Dr Daniel Scott	Staff elected	NONE	
Dr Jim Woods	Stakeholder	**Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies)** **Ownership, part-ownership or directorship of private companies, business or consultancies likely or possibly seeking to do business with the NHS** **Other**	Director of Yorkshire Health Network Ltd Partner: Dr Moss and Partners GP Surgery Partner: Harrogate Medical Services Part Owner: Kings Road Pharmacy Liaison officer for Harrogate Division of North Yorkshire LMC/Chairman Harrogate LMC

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Report to the Trust Council of Governors: 18 May 2016

Title	**Appendix 6.1** **Governor Working Group – Volunteering and Education**
Author(s)	**Mrs Jane Hedley, Public Governor**
Report Purpose	**For information**

This report summarises the items discussed at the last meeting of the Governor Working Group for Volunteering and Education, held on 5 April 2016.

The purpose of the group is to monitor, promote, develop and support the Volunteer Programme, Work Experience and Education Liaison and relevant workforce issues.

Mrs Hedley will highlight the Insight Event presentations by the Allied Health Professionals

Volunteering

We have 390 active volunteers; of these 311 are over 25 and 79 under 25 years of age. Volunteers helped prepare for the Care Quality Commission visit in February and during the week their help was described as 'invaluable'.

Children's Safeguarding training has been available as face to face training as well as e-learning and all volunteers must complete this training to continue their volunteering role.

There are 31 mealtime assistance volunteers covering seven wards and 41 tea time preparation volunteers on five wards where they offer help to patients and prepare their tables for the evening meal.

Seventy-five volunteers from Durham, Darlington & Middlesbrough are joining the Trust, their checks and processes being handled by our Volunteer Co-ordinator.

Lay readers are now included under the volunteering umbrella and among other new opportunities a new volunteer is helping in the Discharge Lounge and one has joined hospital radio. One volunteer acted as an escort for a patient from Ripon and stayed with the patient all afternoon.

Education Liaison

Staff members have attended school careers fairs at Ripon Grammar School and St Aidan's in Harrogate. Emma Edgar and a team from the Cardiology department had a busy evening at Ripon; Maggie Peat and the Research team and Physiotherapists went to St Aidan's. Feedback from the schools has been wonderful with gratitude expressed for the valuable information and advice they passed on. We are very grateful to staff for their time and commitment for these events.

The Insight Event for year 11 students was attended by 57 students from six local schools, when excellent presentations were given by five Allied Health Professionals. These included podiatry, physiotherapy, nutrition & dietetics, occupational therapy and speech & language therapy. Each speciality had a stand and students were able to talk to the professionals afterwards. Details were given about courses, subjects required, job opportunities, hours of work and salaries. An excellent introduction about choosing a career in one of these roles made for a really valuable event, and the feedback was overwhelmingly good.

Work Experience

The team is arranging medical and non-clinical placements for 150 applicants for this summer, which involves one to five days during May – July, for students aged 16-19. They are always pursuing more departments willing to accept students, and have written a useful 'Introduction to Work Experience' document to explain what is involved, guidelines and regulations. There is also an evaluation form for students and staff to complete. Work Experience students will in future wear a lanyard to identify them. It is due to hard work from the team that so many schools are now in contact with the hospital for education and work experience.

Report to the Trust Council of Governors: 18 May 2016

Title	**Appendix 6.2** **Governor Working Group – Membership Development and Communications**
Author(s)	**Ms Pamela Allen, Public Governor**
Report Purpose	**For information**

This report summarises the items discussed at the last meeting of the Governor Working Group for Membership Development and Communications, held on 11 April 2016.

The purpose of the group is to oversee the delivery of the Foundation Trust's Membership Development Strategy, including membership recruitment and engagement.

Ms Allen will highlight the Elections

Medicine for Members' Event

The Medicine for Members' Event was held on 4 May and a second session will be held on 24 May at 12.15 – 1.30pm. The theme of the event is 'Caring for Patients with Dementia.' The session on 4 May was well received and many thanks to the Governors who turned out to help host the session. We anticipate a similar response to the meeting on 24 May.

A Governors drop-in surgery was also held on 4 May prior to the event however there were no public attendees. As this is an opportunity for members to meet and talk with Governors, we will repeat holding a drop-in surgery on 24 May at 1.45 – 2.45pm following to the meeting and evaluate the response.

Annual Members Meeting

The Annual Members' Meeting (AMM) will be held on Tuesday 13 September from 6.00 – 8.00 pm at the Cedar Court Hotel, Park Parade, Harrogate, HG1 5AH. The format will be similar to the event held last year with a short business session, interactive breakout groups and the opportunity to put questions to a panel including Trust staff, Governors and partners from Harrogate and District Clinical Commissioning Group.

The AMM is a statutory meeting and Governors are required to attend.

Elections

Elections will be held between May and August to fill the vacant seat for Ripon and west district and the newly created seat for the Rest of England. The Notice of Election will be issued on 18 May and results will be announced at the beginning of August 2016. A detailed timetable is attached to this report.

A meeting was held with Electoral Reform Services (ERS), the company who currently provides the administration of the election process on behalf of the Trust, and they are offering advice on how to increase awareness of elections with a view to increasing the voting turnout.

The election process will be available on the Trust website including information for members who may be interested in standing for election and regular updates.

Election Timetable

Election Stage	**Date**
Notice of Election	Wednesday, 18 May
Nominations deadline	Thursday, 16 June
Final date for candidate withdrawal	Tuesday, 21 June
Notice of Poll published	Thursday, 7 July
Voting packs despatched	Friday, 8 July
Close of election	Tuesday, 2 August
Declaration of results to Trust	Wednesday, 3 August *

* The Trust will contact all candidates and then publish the results of the election as soon as possible after Wednesday, 3 August.

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Report to the Trust Council of Governors: 18 May 2016

Title	**Appendix 6.3** **Patient and Public Involvement - Learning from Patient Experience**
Author(s)	**Joyce Purkis, Public Governor**
Report Purpose	**For information**

This report summarises the items discussed at the last meeting of the Learning from Patient Experience Group, held on 13 April and 3 May 2016.

The purpose of the group is to understand, monitor, challenge and seek to improve the quality of the experience of users of services provided by HDFT, both in hospital and in the community, taking into account the values of the NHS Constitution and the Trust's Values and Behaviours.

Mrs Purkis will highlight for discussion the Infection Prevention and Control update

Infection prevention and control update

A presentation was given by Dr Jenny Child, Director of Harrogate and District NHS Foundation Trust (HDFT) Infection Prevention and Control and Jenny Featherstone, Team Lead for HDFT Infection Prevention and Control. The team are involved in staff training, identifying problems and offering advice and support on the care of individual patients and the management of infection across the Trust. The risk of getting an infection while in hospital is low but patients already in poor health can be vulnerable. In February 2016, three patients on Oakdale Ward developed Clostridium difficile, a bacteria that is often related to treatment with antibiotics. As this bacteria can remain in the environment for long periods of time if rigorous cleaning is not carried out, the ward was temporally closed for decontamination and no further cases on this ward have occurred. A root cause analysis is conducted in all cases to identify if a lapse in care has occurred or not ie. was there evidence of a lack of adherence to HDFT controls and policies for infection prevention or antibiotic prescribing guidance? If a lapse in care has occurred lessons are learnt to prevent the same situation recurring. Last year, 34 cases of C difficile were reported and seven lapses in care were identified. Three cases have been investigated this year and so far none have been attributable to lapses in care. Targets (ceiling levels) for C difficile infection are set and monitored by Public Health England but Dr Child explained that the ceiling values were based on historical data and since then laboratory methodology for diagnosing the infection has changed; this has led to an apparent rise in the number of cases of C difficile within all NHS Trusts due to increased ascertainment.

The best way to prevent spread is to promptly nurse patients with suspected infection in a side room and ensure staff, patients and visitors clean their hands thoroughly. The infection control team feel that staff practice optimal hand hygiene but asked the Learning from Patient Experience Group if they could suggest ways to further encourage patients to wash their hands regularly. It was suggested that the person delivering the meal trays should present each patient with a soap hand wipe and request that they wash their hands immediately prior to them receiving their meal tray.

Patient Experience and Incident Report (Quarter 4 2015/16)

Twenty-seven surveys capturing patient feedback have been registered with the Clinical Effectiveness team during 2015/16 and include equality monitoring questions. The Friends and Family Test has recently been implemented in outpatients, day surgery and community services. Some problems remain with the automated process for data capture. In March, 94.7% of patients surveyed would recommend the service at HDFT (the latest published national average for percentage recommend is 92.8%).

There are 586 documents on the “Information for Patients” section of the intranet. Of these, 96 are currently passed their review date.

The focus for ongoing work will include:

- Identification of the most common leaflets used across the Trust and a review of these to ensure they are of a consistent and high quality.

- Establishing a rolling programme to review patient information leaflets used within departments, to ensure they are up to date, meeting the Trust standards, that there is robust version control and archiving of previous versions, and that there is a process to seek patient feedback about the leaflets in use.

- Work towards meeting Accessible Information Standards set by NHS England.

Complaints have reduced this year; one of the contributory factors is the introduction of senior nursing staff at weekends and in the evenings. All Directorates have agreed to improve their response times to complaints – now all cases below amber severity should be responded to in < 25 days. The initial response (what happened, what should have happened and what HDFT is going to do) will be in draft form and finalised once feedback from the complainant has been received.

Staff are encouraged to report incidents where no harm has occurred so that action can be taken to avoid repetition.

Elective Care Quality Report (Quarter 4 2015/16)

Falls have decreased on Farndale Ward since the introduction of specialist falls sensor equipment. The Directorate are working hard to reduce the number of "outstanding actions" following complaints and have achieved a 50% decrease since quarter 3.

Chief Nurse Report (April 2016)

The Board of Directors were asked to understand why HDFT currently had registered nurse vacancies and to acknowledge the actions being undertaken to ensure safe nurse staffing levels including robust recruitment campaigns. Nurse recruitment events will take place monthly. Reduction in harm to patients has been achieved through a reduction in hospital acquired pressure ulcers and falls.

Patient Voice Group update

The Patient Voice Group have arranged to visit two community nursing teams, Granby Ward, Oakdale Ward, Byland Ward and Wensleydale Ward. The Group are awaiting the Trust's response to their report on Littondale ward and an update on the Children's Project Action Plan.

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Harrogate and District NHS
NHS Foundation Trust

QUALITY PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE

Priorities for improvement 2016/17

1. Reduce morbidity and mortality related to sepsis

There is a national focus on reducing morbidity and mortality related to sepsis, with inclusion in the national Commissioning for Quality and Innovation (CQUIN) scheme for 2015/16 and 2016/17. We will be aiming to achieve the national CQUIN requirements relating to sepsis screening, treatment and review in the Emergency Department (ED) and for inpatients. The metrics that will be used to monitor performance and improvement are:

- CQUIN audit data;
- Case note review of patient deaths resulting from sepsis;
- Sepsis mortality rate.

2. Improve care of people with learning disabilities

This relates to the Trust' Equality and Diversity objectives and we aim to increase the identification of people with learning disabilities (LD) by using, with their consent, electronic flags on electronic patient systems. This will enable staff to identify people who may need additional support and to use that information to deliver high quality, personalised care. The metrics that can be used to monitor performance and progress are:

- Number of LD flags on hospital systems;
- Demonstration of using information to provide personalised care;
- Patient / carer feedback from the Friends and Family Test (FFT) and other surveys, complaints, compliments;
- Staff training levels.

3. Provide high quality stroke care - demonstrated by improvement in national indicators

Whilst some of our Sentinel Stroke National Audit Programme (SSNAP) results have improved recently, we are not making as much progress as we would like with others, and we want to focus during 2016/17 on improving our performance in relation to the provision of high quality stroke care. The quarterly SSNAP dataset will be used to monitor performance and progress.

4. Improve the management of inpatients on insulin

We are focusing on this because of increasing medicines safety incidents including serious incidents requiring investigation (SIRI) that relate to insulin prescription and administration. The metrics for monitoring performance and progress include:

- Datix (patient safety and risk management software) reports relating to insulin management;
- Actions taken as a result of abnormal results e.g. inpatients with episode of hypoglycaemia, raised capillary blood glucose as indicated on the insulin dashboard;
- Staff training.

Harrogate and District NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS: 18 May 2016

Report Title:	**Report from Remuneration Committee for Non-Executive Directors including the Chairman**
Report From:	**Ms Pamela Allen, Deputy Chair of Council of Governors/Public Governor**
Report Purpose:	**To consider and approve the recommendations including ratification of the Terms of Reference and Minutes, 5 May 2016**

1. Introduction and Background

The NHS Foundation Trust Code of Governance clearly states that the Council of Governors is responsible for setting the remuneration of Non-Executive Directors and the Chairman. The levels of remuneration should reflect the time commitment and responsibility of roles.

The Remuneration Committee met on 5 May 2016 to discuss the remuneration for the Chairman and Non-Executive Directors in the coming 2016/17 financial year. **The Council of Governors is asked to approve the Terms of Reference attached at Appendix A and members of the Remuneration Committee are asked to ratify the minutes of the meeting attached at Appendix B.**

2. The role of the Chair and Non-Executive Directors

There is a clear division of responsibilities at senior levels within the Trust between the Chair and Non-Executive Directors and the Executive Directors.

In summary, the Chair of the Foundation Trust is responsible and accountable for:-

- Promoting the highest standards of integrity, probity and corporate governance throughout the organisation and particularly at the level of the Board of Directors;
- Demonstrating visible and ethical personal leadership by modelling the highest standards of personal behaviour and ensuring that the Board of Directors emulates this example;
- Leading the board in establishing effective decision-making processes and acting as the guardian of the due process;
- Ensuring that constructive relations based on candour, trust and mutual respect exist between Executive and Non-Executive Directors, elected and appointed members of the Council of Governors and between the Board of Directors and the Council of Governors;
- Developing productive working relationships with all Executive Directors and the Chief Executive in particular, providing support, guidance and advice;

- Promoting an understanding of the role of the board, the scheme of delegations, the role of non-Executive Directors and the role of Executive Directors; and
- General leadership of the Board of Directors and the Council of Governors, ensuring that the Board of Directors and Council of Governors work together effectively.

The role of the Non-Executive Director is to bring an independent perspective to the boardroom on issues of strategy, performance and resources, including key appointments and standards of conduct. This is in addition to any specific knowledge and skills they may have. Non-Executive Directors have a duty to uphold the highest standards of integrity and probity and foster good relations in the boardroom.

The Trust has a 'Unitary Board', meaning there is no legal distinction between Executive and Non-Executive Directors. Non-Executive Directors have the same legal duties, responsibilities and potential liabilities as the Executive Directors.

All Directors should be capable of seeing Trust issues in a broad perspective. Nonetheless, Non-Executive Directors are recruited because they have a breadth of experience, are of an appropriate calibre and have particular personal qualities. Additionally, they have some specialist knowledge that helps provide the board with valuable insights or, perhaps, key contacts in related services.

Of the utmost importance is their independence. This means they bring objectivity to the deliberations of the Board of Directors.

The key responsibilities of the Non-Executive Directors include the following:

- Supporting the Chair, Chief Executive and Executive Directors in promoting the Foundation Trust's values;
- Supporting a positive culture throughout the Foundation Trust and adopt behaviours in the boardroom and elsewhere that exemplify the corporate culture;
- Constructively challenging the decisions of the board and ensure that appropriate challenge is made in all circumstances;
- Helping develop proposals on priorities;
- Helping develop proposals on values and standards; and
- Contributing to the development of strategy.

Non-Executive Directors have a duty to:

- Scrutinise the performance of the executive management in meeting agreed goals and objectives;
- Satisfy themselves as to the integrity of financial, clinical and other information
- Satisfy themselves that financial and clinical quality controls and systems of risk, management and governance are sound and that they are used; and
- Ensure that they receive adequate information in the form that they specify and to monitor the reporting of performance.

Non-Executive Directors are responsible for:

- Determining appropriate levels of remuneration of Executive Directors;
- Appointing the Chief Executive;
- Appointing other Executive Directors; and

- Succession planning for key executive posts

The Non-Executive Directors, additionally to their Board of Directors role, provide general counsel based on their knowledge and expertise such that the Chairman and Chief Executive may seek their guidance on particular issues. Some of the work of the Non-Executive Directors will be carried out in sub-committees, for example the Audit Committee.

3. Holding Non-Executive Directors to account

In accordance with the Health and Social Care Act 2012, the Council of Governors has a statutory responsibility to hold Non-Executive Directors to account for the performance of the Board of Directors. To fulfil this duty, the Council of Governors must seek assurance through the performance review process described below, that the Non-Executive Directors are performing to an expected standard. This information must be taken into account when reviewing and setting remuneration for the Chair and Non-Executive Directors.

4. Performance Reviews

In compliance with Trust policy, all Non-Executive Directors undertook performance reviews with the Chairman in 2015/16. All Non-Executive Directors were considered to be performing at an outstanding level, and no specific issues were identified. The Deputy Chair of Governors appraises the Chair with the Senior Independent Director (SID) and accompanies the Chair on all Non-Executive Director appraisals.

5. Market analysis

The Remuneration Committee received detailed salary benchmarking information collected by CAPITA from 2014/15 Annual Reports and by NHS Providers from the 2015 annual remuneration survey and considered this in relation to the current remuneration received by the Chairman and Non-Executive Directors.

6. Considerations of the Remuneration Committee

Mrs Harrison, Deputy Director of Workforce and Organisational Development and Miss Henderson, Company Secretary provided detail in their report to the Remuneration Committee confirming the Department of Health via NHS Employers had recently confirmed the cost of living uplift for all staff employed on Agenda for Change terms and conditions of service and medical and dental terms and conditions of service. All pay rates had been increased by 1% from 1 April 2016. A recommendation on Very Senior Managers (VSMs) cost of living uplift had not yet been confirmed, but was also expected to be 1%.

The Remuneration Committee were also asked to note that for comparative purposes, from 1 April 2016, Harrogate and District NHS Foundation Trust had an annual revenue of £215m and 4,213 headcount (3,326 WTE employed). This significant increase in both revenue and workforce size relate primarily to the successful acquisition of children's services from County Durham and Darlington NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. This significant increase was noteworthy in that it had moved the Trust into a new comparative banding group for Executive remuneration purposes in the CAPITA

report and the rationale for increasing the salaries this year would bring the Trust in line with the upper quartile of Foundation Trusts rather than the average.

Finally, the Remuneration Committee were asked to consider the future remuneration of the Non-Executive Directors with additional responsibilities for chairing the Quality Committee and Finance Committee as the Non-Executive Director chairing the Audit Committee already received an enhancement for this additional responsibility.

The Remuneration Committee considered the following options:

1. Applying cost of living uplift to the Non-Executive Directors and Chairman of the Trust, consistent with VSMs in Clinical Commissioning Groups and Area Teams from 1 April 2016 when this was announced.

2. The remuneration of the Chairman and Non-Executive Directors taking into account the factors highlighted in the detailed paper.

3. The future remuneration of the Non-Executive Director role with responsibility for the Quality Committee and Finance Committee; new sub-committees of the Board established during 2015/16.

7. Recommendations of the Remuneration Committee from the meeting on 5 May 2016

The Remuneration Committee held a detailed discussion around the role of the Non-Executive Directors including the Chairman, salary details and guidance received.

The recommendation of the Remuneration Committee is as follows

1. To apply a cost of living uplift to the Non-Executive Directors and Chairman of the Trust, consistent with VSMs in Clinical Commissioning Groups and Area Teams from 1 April 2016 when this is formally announced.

2. To recommend the remuneration as follows:
    - Non-Executive Director with no additional responsibilities - £13,000
    - Non-Executive Director with responsibility for chairmanship of the Quality Committee and Finance Committee - £14,000
    - Non-Executive Director with statutory responsibility as chair of the Audit Committee, Senior Independent Director and Vice Chair - £16,500
    - Chairman - £48,500

On behalf of the Council of Governors, the Governors on the Committee acknowledged the continued hard work and dedication of the Non- Executive Directors including the Chairman and pass on their thanks.

The Council of Governors is asked to consider and approve the recommendation of the Remuneration Committee

Appendix A

Harrogate and District NHS
NHS Foundation Trust

REMUNERATION SUB-COMMITTEE FOR THE CHAIR AND NON-EXECUTIVE DIRECTORS

COMPOSITION AND TERMS OF REFERENCE

1. Purpose

As laid down in the Constitution Remuneration Sub-Committee (the Sub-Committee) is to be established for the purposes of setting the remuneration of the Chairman and other Non-Executive Directors. The sub-committee will make a recommendation to the Council of Governors in relation to the annual remuneration of the Non-Executive Directors of Harrogate and District NHS Foundation Trust.

2. Membership

The membership of the Sub-Committee shall consist of:

- A minimum of four Governors, at least three being public;
- The Chief Executive;
- The Director of Workforce and Organisational Development;
- The Director of Finance;
- The Company Secretary; and,
- The Corporate Affairs and Membership Manager.

The Sub-Committee shall report to the Council of Governors in writing at its next meeting.

All meetings of the Committee will be minuted.

3. Chair of the Remuneration Sub-Committee

3.1 The Sub-Committee will be chaired by an identified Governor, usually the Deputy Chair of Governors.

4. Support for the Remuneration Sub-Committee

The Director of Workforce and Organisational Development will provide information and advice to the Sub-Committee to ensure compliance with best practice. The meetings of the Sub-Committee will be recorded in the form of minutes.

5. Responsibilities of the Remuneration Sub-Committee

5.1 To recommend to the Council of Governors remuneration packages for the Non-Executive Directors and Chairman of the Trust in line with current market intelligence.

5.2 To judge where to position the Trust relative to other NHS Foundation Trusts and comparable companies in relation to remuneration levels.

5.3 To be sensitive to pay and employment conditions elsewhere in the Trust when determining any salary increase.

5.4 The Deputy Chair of the Council of Governors will assist in monitoring and evaluating the performance and development of the Non-Executive Directors and Chairman through the annual appraisal mechanism.

6. Quorum

A quorum is five members, three of which being Governors.

7. Frequency of meetings

The Sub-Committee will meet on an annual basis. Additional meetings will be called as required.

8. Notice of meetings

Meetings of the Sub-Committee will be called at the request of the Council of Governors.

Details of each meeting including agenda and supporting papers will be forwarded to each member of the Sub-Committee five working days before the date of the meeting.

9. Minutes of meetings

Minutes of the meetings will be circulated to all members of the Sub-Committee and to all other members of the Council of Governors, then to the Board of Directors as soon as reasonably practical.

10. Reporting arrangements

The proceedings and recommendation of the Sub-Committee will be reported to the next meeting of the Council of Governors.

11. Authority

The Sub-Committee is authorised to seek information and advice either within the trust or externally on any matters within its terms of reference.

12. Review

These terms of reference will be reviewed annually and approved by the Council of Governors.

Harrogate and District NHS
NHS Foundation Trust

MINUTES OF THE REMUNERATION COMMITTEE FOR NON-EXECUTIVE DIRECTORS INCLUDING THE CHAIRMAN
Held on 5 May 2016 in the Boardroom, Trust HQ,
Harrogate District Hospital

Present Members:	Ms Pamela Allen, Public Governor/Deputy Chair of Governors (Chair) Ms Clare Cressey, Staff Governor Mrs Liz Dean, Public Governor Mr Tony Doveston, Public Governor Mrs Emma Edgar, Staff Governor Mrs Joyce Purkis, Public Governor
Ex Officio:	Mrs Colvin, Corporate Affairs and Membership Manager Mr Jonathan Coulter, Deputy Chief Executive/Finance Director Mrs Joanne Harrison, Deputy Director of Workforce and Organisational Development Miss Debbie Henderson, Company Secretary Mr Phillip Marshall, Director of Workforce and Organisational Development Dr Ros Tolcher, Chief Executive

1. Apologies for absence

Apologies were received from Dr Sally Blackburn, Public Governor, Cllr. John Ennis, Stakeholder Governor, Mrs Jane Hedley, Public Governor, Mrs Sally Margerison, Staff Governor and Dr Jim Woods, Stakeholder Governor.

Ms Allen welcomed everyone and confirmed the meeting was quorate.

2. Terms of Reference

The Committee made no changes to the Terms of Reference, circulated prior to the meeting, and this would be noted at the next Council of Governor meeting on 18 May for ratification.

3. Remuneration of Non-Executive Directors including market intelligence and benchmarking

Mr Marshall referred to Paper 2, kindly prepared by Mrs Harrison and Miss Henderson, which had been circulated prior to the meeting and taken as read.

In accordance with the NHS Foundation Trust's Code of Governance and the Trust's Constitution, the Council of Governors is responsible for setting the remuneration of the Non-Executive Directors including the Chairman.

The content of the paper provided detailed comparative Chair and Non-Executive remuneration from two sources; CAPITA NHS Foundation Trust Board Remuneration Report 2016 and NHS Providers Annual Remuneration Survey Non-Executive Director Results 2015. Mr Marshall asked the Committee to note that from 1 April 2016 the Trust had increased significantly in size and accountability following the successful acquisition of children's services from County Durham and Darlington NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. For comparative purposes, the Trust's annual revenue had increased from £186m to £215m. The paper also provided the roles and responsibilities of the Chairman and Non-Executive Directors and performance reviews. Mr Marshall added that the appraisal process for 2016/17 was currently being written up and Ms Allen confirmed this.

Mr Marshall stated that the data collected by CAPITA was drawn from the 2014/15 Annual Report and Accounts and showed the salary levels paid for the Chair, Deputy Chair (Vice Chair) plus Senior Independent Director (SID), Audit Chair and SID, Audit Chair, Deputy Chair (Vice Chair), SID and Non-Executive Directors in all Foundation Trusts. Information was also provided showing the proportion of Trusts paying Non-Executive Directors extra salary for additional responsibilities. Data collected by NHS Providers from the 2015 annual remuneration survey was relatively new information and provided salary levels for Chairs and Non-Executive Directors in all Foundation Trusts along with a breakdown of the percentage of Trusts applying uplifts to Non-Executive Director for the additional roles of SID, Audit Chair and Vice Chair.

4. Determination of remuneration for 2016/17

The Committee noted that the Department of Health via NHS Employers had recently confirmed the cost of living uplift for all staff employed on Agenda for Change terms and conditions of service and medical and dental terms and conditions of service. All pay rates had been increased by 1% from 1 April 2016.

Mr Marshall reported that a recommendation on Very Senior Managers cost of living uplift had not yet been confirmed, but was also expected to be 1%.

Finally, Mr Marshall asked the Committee to consider the future remuneration of the Non-Executive Directors with additional responsibilities for chairing the Quality Committee and Finance Committee as the Non-Executive Director chairing the Audit Committee already received an enhancement for this additional responsibility.

The Committee reviewed the information provided and assessed both the responsibilities and remuneration of the Chairman and Non-Executive Directors, including those with additional responsibilities, in comparison with other Trusts.

A detailed discussion followed with each Governor analysing the data provided and giving consideration to a number of factors for each role. This included discussing the rationale for increasing the salaries this year in line with the upper quartile of Foundation Trusts rather

than the average before agreeing their recommendation. Further guidance was sought from Executive Directors in attendance on the comparative data.

The Committee also noted that Non-Executive Directors, including the Chairman, had not been awarded a cost of living award uplift for the last three years.

Taking into account the information provided, the Remuneration Committee was asked to consider:

1. Applying cost of living uplift to the Non-Executive Directors and Chairman of the Trust, consistent with VSMs in Clinical Commissioning Groups and Area Teams from 1 April 2016 when this was announced.

2. The remuneration of the Chairman and Non-Executive Directors taking into account the factors highlighted in Section1 of Paper 2.

3. The future remuneration of the Non-Executive Director role with responsibility for the Quality Committee and Finance Committee; new sub-committees of the Board established during 2015/16.

The recommendation of the Remuneration Committee, which would be subject to ratification at the next Council of Governors meeting on 18 May 2016, was as follows:

1. To apply a cost of living uplift to the Non-Executive Directors and Chairman of the Trust, consistent with VSMs in Clinical Commissioning Groups and Area Teams from 1 April 2016 when this is formally announced.

2. To recommend the remuneration as follows:

    - Non-Executive Director with no additional responsibilities - £13,000
    - Non-Executive Director with responsibility for chairmanship of the Quality Committee and Finance Committee - £14,000
    - Non-Executive Director with statutory responsibility as chair of the Audit Committee, Senior Independent Director and Vice Chair - £16,500
    - Chairman - £48,500

Governors on the Committee recognised the value that Non-Executive Directors bring to the Trust and acknowledge their continued hard work and dedication.

5. Any other business

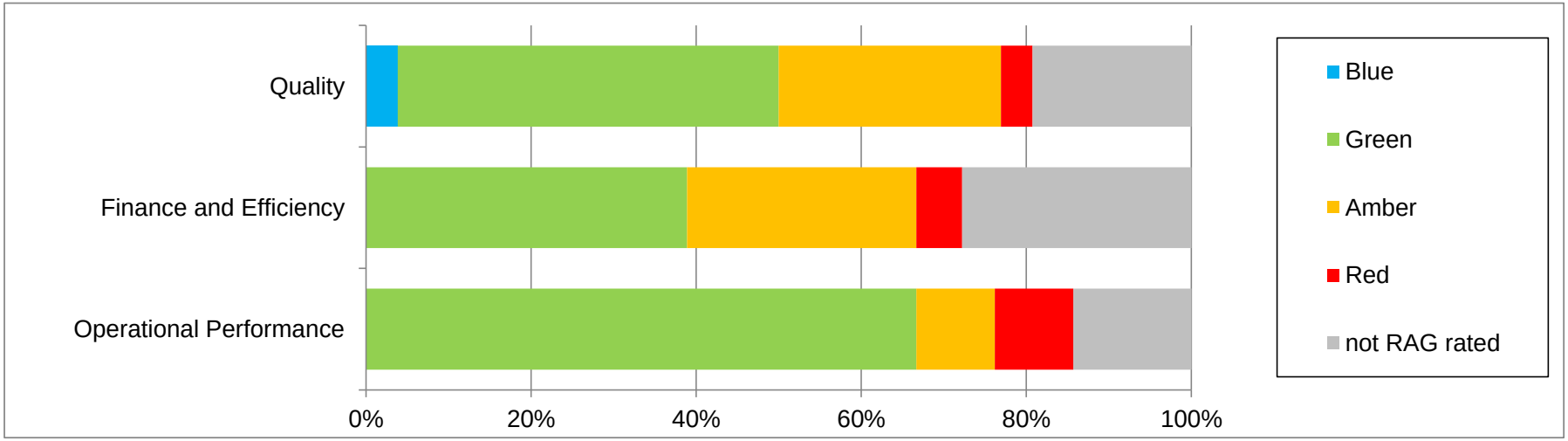
There was no other business.

Integrated board report - March 2016

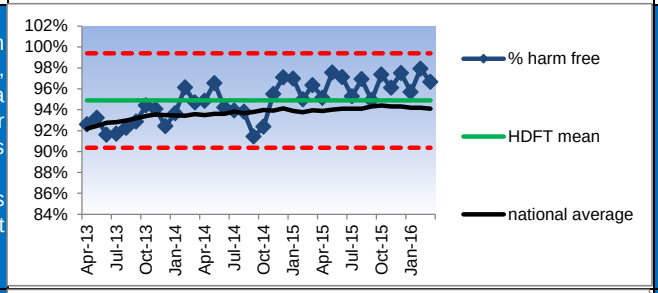
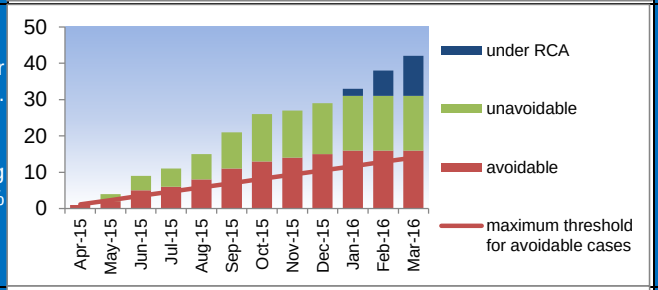
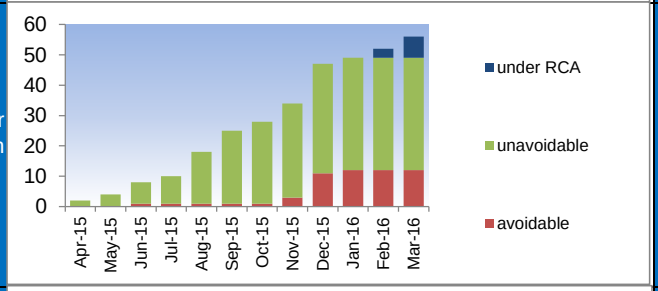
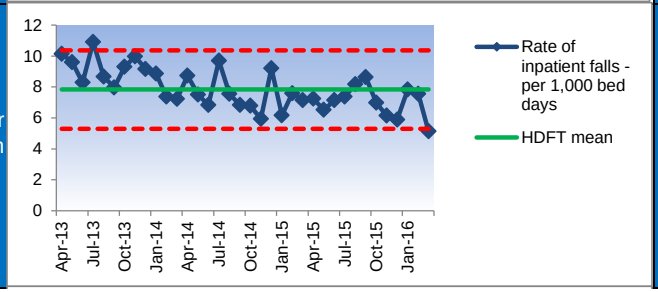
Key points this month

1. Both standardised mortality measures (HSMR and SHMI) reduced this month. HDFT's SHMI remains below expected levels.
2. The number of hospital acquired C. diff cases reported during 2015/16 was 34, of which 7 were deemed to be due to a lapse in care. 4 cases are still under root cause analysis.
3. The agency bill for March was 3.16% of Trust pay expenditure, an increase on last month. Detailed work is ongoing with Clinical Directorates to reduce total agency spend and ensure compliance with the agency cap.
4. Performance against the A&E 4 hour standard was below the required 95% level in March and for Quarter 4 overall.
5. The Trust achieved all cancer waiting times standards in each quarter of 2015/16.

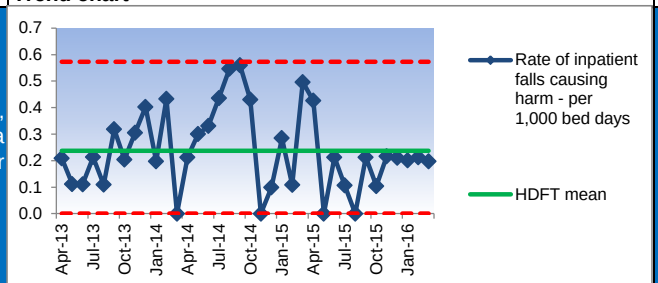
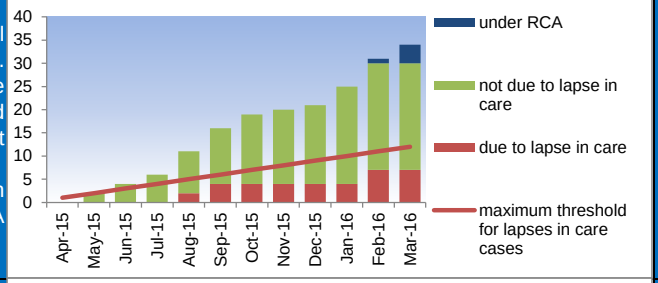
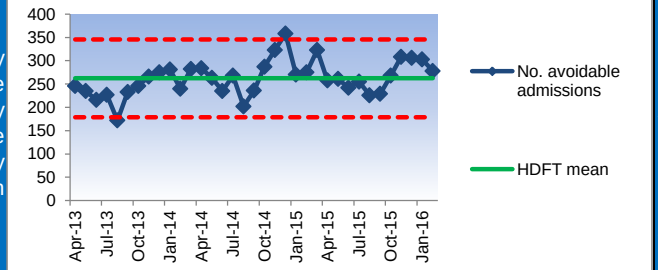
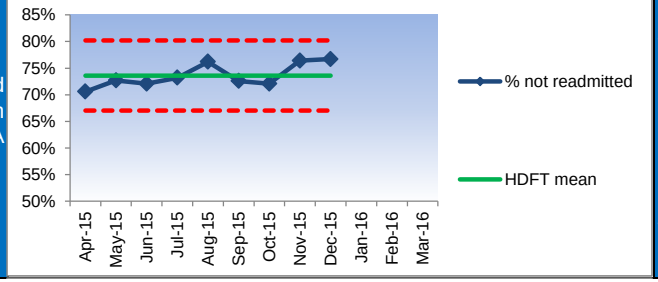
Summary of indicators



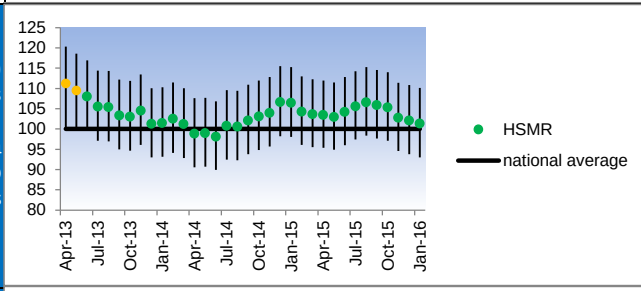
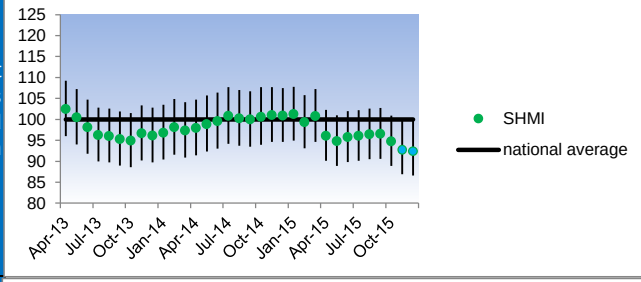
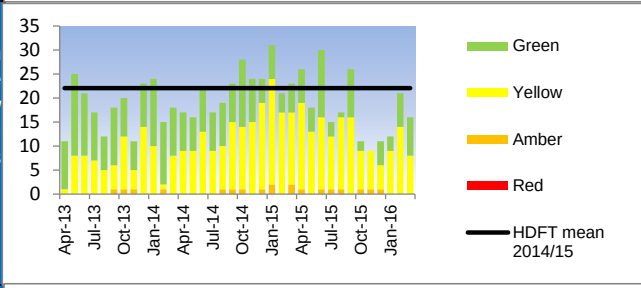
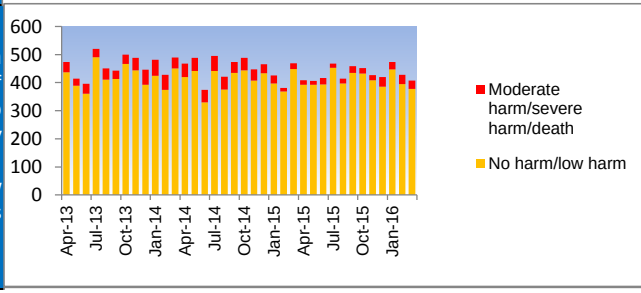
Quality - March 2016

Indicator	Description	Trend chart	Interpretation
Safety thermometer - harm free care	Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.		The harm free percentage for March was 96.7%, a decrease on the previous month but still above the 95% standard and well above the national average of 94.1%.
Pressure ulcers - hospital acquired	The chart shows the cumulative number of grade 3 or grade 4 hospital acquired pressure ulcers in 2015/16. The data includes hospital teams only. A maximum threshold of 14 avoidable cases during 2015/16 has been locally agreed. This reflects a 50% reduction on last year's figure.		There were 42 hospital acquired grade 3 or grade 4 pressure ulcers reported in 2015/16, of which 16 were deemed avoidable, which is above our locally agreed performance trajectory of a maximum of 14 avoidable cases. The total number of category 2, 3 and 4 pressure ulcers reported during 2015/16 was 155 (across hospital and community services) representing a reduction of 36% on 2014/15. The Trust set a target of a 20% total reduction.
Pressure ulcers - community acquired	The chart shows the cumulative number of grade 3 or grade 4 community acquired pressure ulcers in 2015/16. The data includes community teams only.		There were 56 community acquired grade 3 or grade 4 pressure ulcers reported in 2015/16, of which 12 were deemed avoidable, 37 unavoidable and 7 are still under root cause analysis (RCA). The pressure ulcer working group is focussing on better assessment and verification of grading within the community teams.
Falls	The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good.		The rate of inpatient falls was 5.1 per 1,000 bed days in March, a significant decrease on the previous month and below the average HDFT rate during 2014/15. The falls sensors are now in place on Byland, Jervaulx and Farndale wards and there is a plan to roll out to the other ward areas.

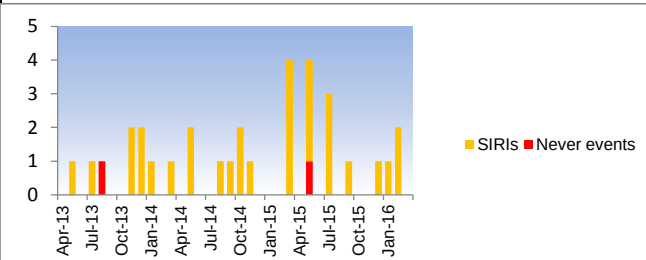
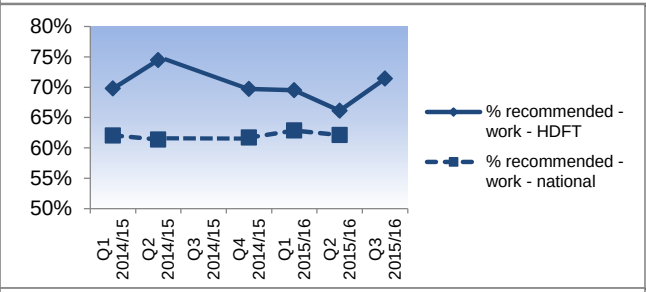
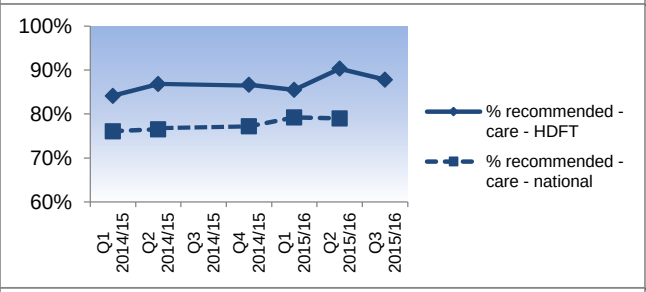
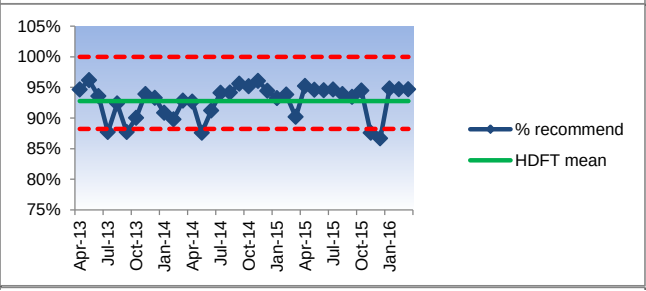
Quality - March 2016

Indicator	Description	Trend chart	Interpretation
Falls causing harm	The number of inpatient falls causing significant harm, expressed as a rate per 1,000 bed days. The data includes falls causing moderate harm, severe harm or death. A low rate is good.		The rate of inpatient falls causing significant harm was 0.19 per 1,000 bed days in March, a decrease on the previous month and below the average HDFT rate during 2014/15. There were 20 inpatient falls causing moderate or severe harm in 2015/16, of which 16 resulted in a fracture. This compares to 36 moderate or severe harm falls in 2014/15, representing a 45% reduction.
Infection control	The chart shows the cumulative number of hospital acquired C. difficile cases during 2015/16. HDFT's C. difficile trajectory for 2015/16 is 12 cases. Cases where a lapse in care has been deemed to have occurred would count towards the Monitor risk assessment framework. Hospital acquired MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2015/16.		There were 3 cases of hospital acquired C. difficile reported in March, bringing the year to date total to 34. Root cause analysis (RCA) results indicate that 7 cases were deemed to be due to a lapse in care and 23 were not. 4 cases are still under RCA. No cases of hospital acquired MRSA were reported in 2015/16 to date.
Avoidable admissions	The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.		The number of avoidable admissions decreased in February, and is slightly lower than last February. An admission avoidance/urgent care project group has been established and the Trust is working with HARD CCG to develop care models and pathways that support patients to stay in their own home and reduce the risk of hospital admissions. This is also the focus of the New Care Models work and one of the metrics being used to evaluate this pilot.
Reducing readmissions in older people	The chart shows the proportion of older people aged 65+ who were still at home 91 days after discharge from hospital into rehabilitation or reablement services. A high figure is good. *This indicator is in development.*		We have amended the calculation of this indicator so that it correctly handles patients who had multiple admissions and multiple contacts with community services. For patients discharged in December, 77% were still in their own home at the end of March, a slight increase on the previous month. This is also the focus of the New Care Models work and one of the metrics being used to evaluate this pilot.

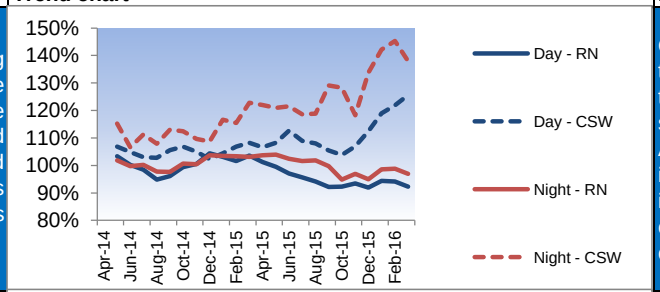
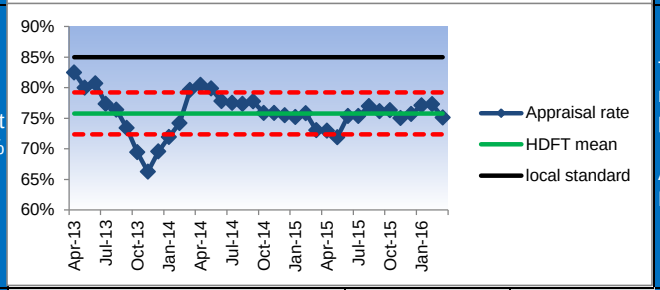
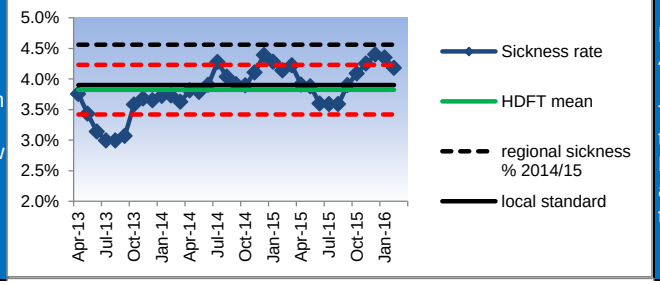
Quality - March 2016

Indicator	Description	Trend chart	Interpretation
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.		HDFT's HSMR decreased again in January to 101.31. It is above the national average but within expected levels. At specialty level, 2 specialties (Geriatric Medicine and Gastroenterology) have a standardised mortality rate above expected levels. At site level, Ripon Hospital standardised mortality is now within expected levels.
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.		HDFT's SHMI decreased again in November to 92.42 - this is below the national average and below expected levels for the second consecutive month. It is also the lowest level reported by the Trust in the last 3 years. At specialty level, 2 specialties (Geriatric Meidicine and Gastroenterology) have a standardised mortality rate above expected levels and looking at the data by site, Ripon hospital has a higher than expected mortality rate.
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.		16 complaints were received in March (none of which were classified as amber or red) compared to 21 last month. The recent introduction of matrons at the weekends and on evening shifts is believed to be continuing to contribute to a reduction in the number of complaints received overall.
Incidents - all	The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture		There were 407 incidents reported in March. The number of incidents reported each month remains fairly static but the proportion classified as moderate harm, severe harm or death has reduced over the last 3 years. The latest published national data (for the 6 month period to end March 2015) showed that acute trusts reported an average ratio of 25 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's local reporting ratio for 2015/16 to date is 16.2.

Quality - March 2016

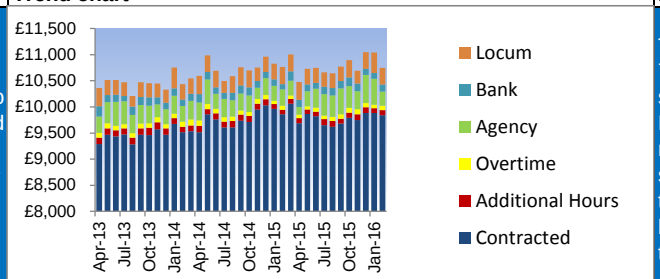
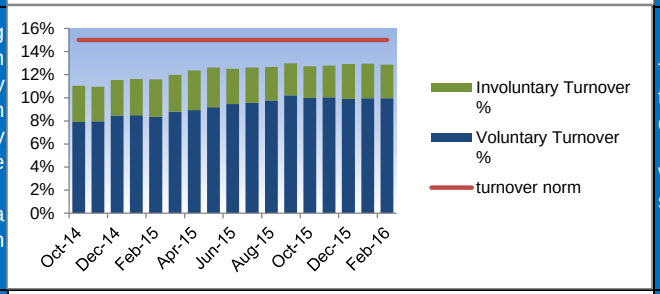
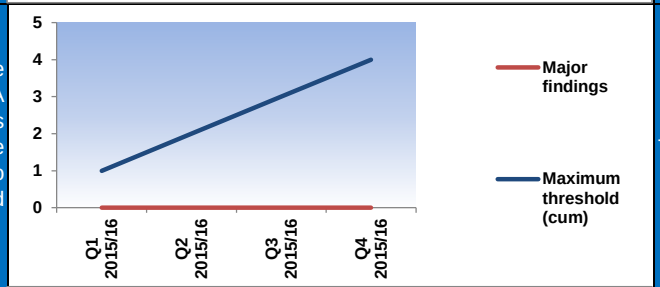
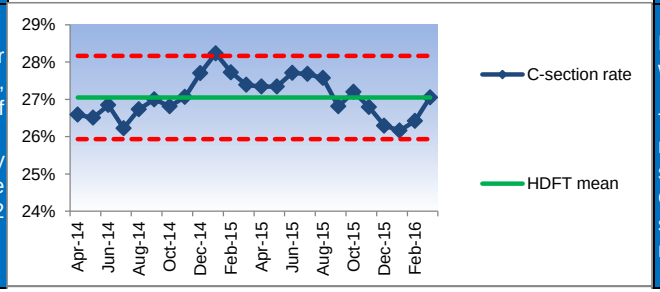
Indicator	Description	Trend chart	Interpretation
Incidents - SIRIs and never events	The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services.		There were no SIRIs and no never events reported in March.
Friends & Family Test (FFT) - Staff - % recommend as a place to work	The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. The chart shows the percentage of staff that would recommend the Trust as a place to work. A high percentage is good. The Trusts aim is to feature in the top 20% of Trusts nationally.		*There is no update of this data this month.* In Q4 2015/16, staff from Integrated Care Directorate and some staff from Corporate Directorate (Estates and Hotel Services) were surveyed. The survey has now closed and we are awaiting the data.
Friends & Family Test (FFT) - Staff - % recommend as a place to receive care	The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. The chart shows the percentage of staff that would recommend the Trust as a place to work. A high percentage is good. The Trusts aim is to feature in the top 20% of Trusts nationally.		*There is no update of this data this month.* In Q4 2015/16, staff from Integrated Care Directorate and some staff from Corporate Directorate (Estates and Hotel Services) were surveyed. The survey has now closed and we are awaiting the data.
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.		The % of patients recommending our services was 94.7% in March. The latest published national average is 92.8%.

Quality - March 2016

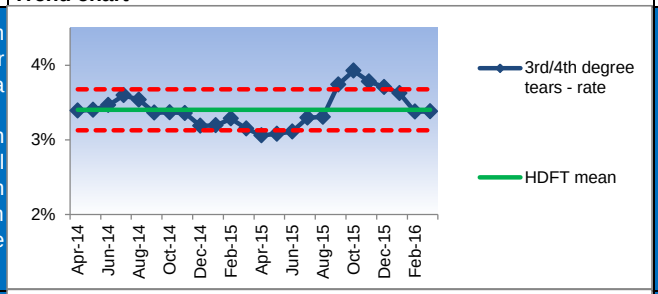
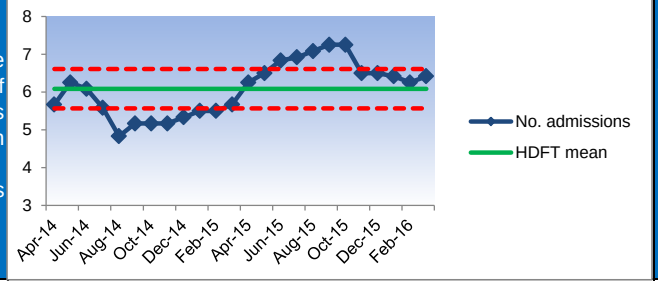
Indicator	Description	Trend chart	Interpretation
Safer staffing levels	Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website.		Overall staffing compared to planned was at 105%, compared to 106% last month. CSW staffing remains very high compared to plan - this is reflective of the increased need for 1-1 care for some inpatients. A significant focus is being placed on recruitment of RN staff including open events and targeted recruitment campaigns including the use of social media. Senior nurses continue to engage with students who have committed their future to this organisation and accepted a position for September.
Staff appraisal rates	The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 85% of staff appraised. A high percentage is good.		The locally reported cumulative appraisal rate for the 12 months to end March 2016 was 75.1%, a decrease on the previous month. Appraisal rate compliance will be addressed at Clinical Directorate board meetings this month.
Mandatory training rates	The table shows the most recent training rates for all mandatory elements for substantive staff. A high percentage is good.		The data shown is for end March. The overall training rate for mandatory elements for substantive staff is 94.8%, compared to 93.6% last month. The Information Governance toolkit requires us to achieve 95% for both information governance training elements. Following a significant focus on this area through Operational Delivery Group, the 95% standard was achieved for the end of March.
Sickness rates	Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%. A low percentage is good.		HDFT's staff sickness rate has seen a decrease in February to 4.18%. There will be a rollout of specific Mentally Healthy Workplace training, which is a follow up to the successful series of Personal Resilience workshops carried out in 2015. Sessions are open to all staff and aim to provide skills to reduce stress in the workplace environment.

Competence Name	Total Employees	% Completed
Equality and Diversity - General Awareness	3449	95
Fire Safety Awareness	3449	92
Health & Safety	1491	99
Infection Prevention & Control 1	660	100
Infection Prevention & Control 2	2740	88
Information Governance: Introduction	3182	95
Information Governance: The Beginners Guide	266	98
Prevent Basic Awareness (December 2015)	3449	100
Safeguarding Children & Young People Level 1	3449	94

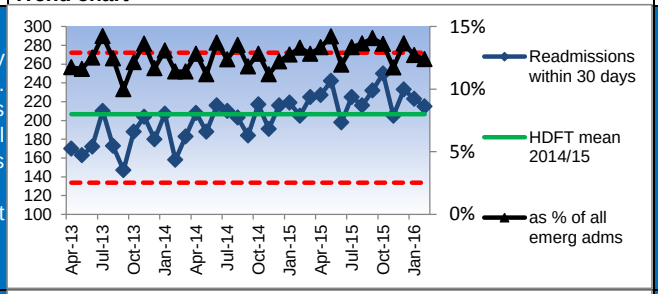
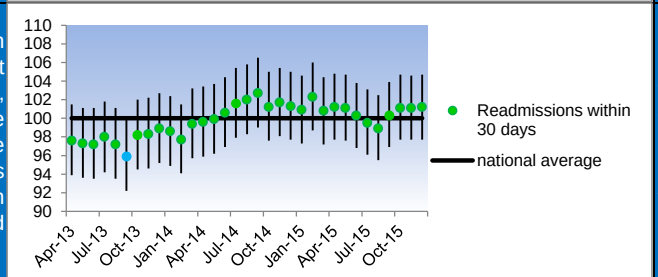
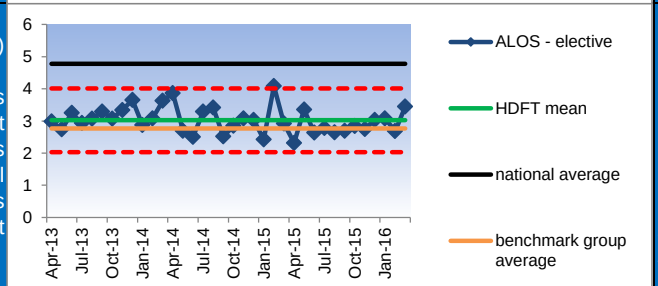
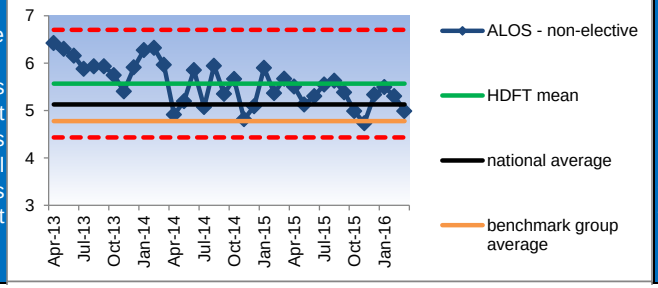
Quality - March 2016

Indicator	Description	Trend chart	Interpretation
Temporary staffing expenditure - medical/nursing /other	The chart shows staff expenditure per month, split into contracted staff, overtime and additional hours and temporary staff. Lower figures are preferable. *The traffic light criteria applied to this indicator is currently under review.*		The proportion of spend on temporary staff during 2015/16 was 7.6%, compared to 7.1% last year. It is to be noted that the total staffing spend is in line with budgeted spend in month. However concern remains regarding the number of registered nurse vacancies and the impact this is having on agency spend. Sickness will also be a driver of increased use of temporary and agency staff. Registered Nurses have recently been added to the National Shortage Occupation List given that the current demand is greater than supply nationally.
Staff turnover rate	The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.		Turnover rates are remaining fairly static with the Trust rate for the rolling 12 months to February 2016 being 12.86%, a slight decrease from 12.96% seen last month. Work continues to focus on areas with high levels of turnover, such as nursing and ODPs.
Research internal monitoring	The Trust internally monitors research studies active within the Trust. The department mirrors the MHRA categorisation of critical, major and other findings (departures from legislative or GCP requirements). The department has set a standard of no critical and no more than four major findings per annum. Major and other findings are non-notifiable and dealt with locally.		There were no critical or major findings reported in 2015/16.
Maternity - Caesarean section rate	The caesarean section rate is determined by a number of factors including ability to provide 1-1 care in labour, previous birth experience and confidence and ability of the staff providing care in labour. The rate of caesarean section can fluctuate significantly from month to month - as a result we have amended the presentation of this indicator this month to show a 12 month rolling average position.		HDFT's C-section rate for the 12 months ending March 2016 was 27.1% of deliveries, an increase on last month. The Royal College of Obstetricians and Gynaecologists recently published a paper which included a range of metrics standardised for local populations, including C-section rates. Overall HDFT was "as expected" in terms of standardised C-section rates. The report is being reviewed in detail by the maternity team to benchmark our position.

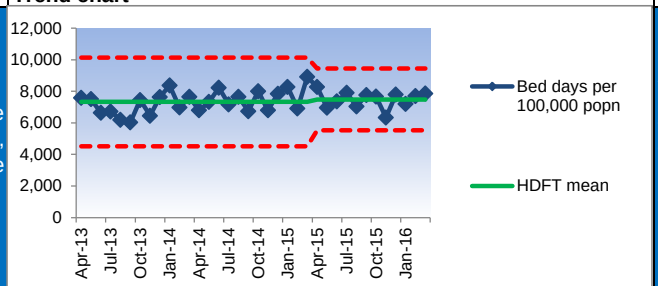
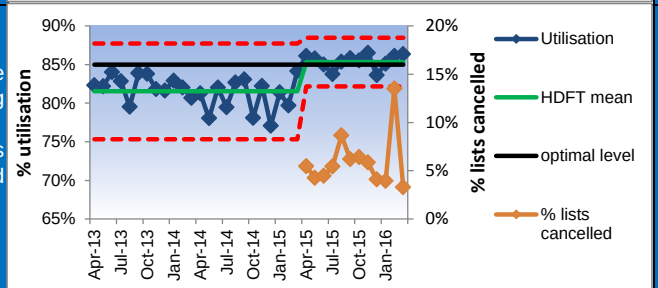
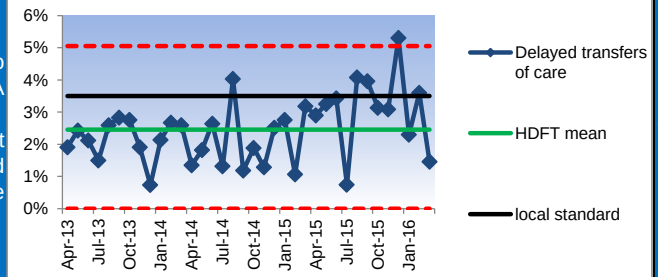
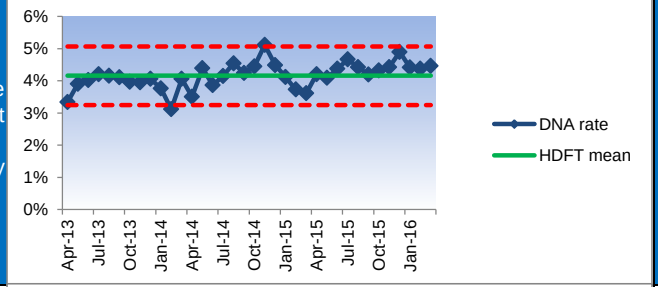
Quality - March 2016

Indicator	Description	Trend chart	Interpretation
Maternity - Rate of third and fourth degree tears	Third and fourth degree tears are a source of short term and long term morbidity. A previous third degree tear can increase the likelihood of a woman choosing a caesarean section in a subsequent pregnancy. Recent intelligence suggested that HDFT were an outlier for third degree tears with operative vaginal delivery. Quality improvement work is being undertaken to understand and improve this position and its inclusion on this dashboard will allow the Trust Board to have sight of the results of this.		The rate of 3rd/4th degree tears was 3.4% of deliveries in the 12 month period ending March 2016, no change on last month. The maternity team carry out a full review of all cases of 3rd/4th degree tears. Consideration is currently being made to a clinical re-audit of 3rd/4th degree tears occurring with normal deliveries.
Maternity - Unexpected term admissions to SCBU	This indicator is a reflection of the intrapartum care provided. For example, an increase in the number of term admissions to special care might reflect issues with understanding of fetal heart rate monitoring in labour. We have amended the presentation of this indicator this month to show a 12 month rolling average position.		The chart shows the number of babies born at greater than 37 weeks gestation who were admitted to the Special Care Baby Unit (SCBU). The maternity team carry out a full review of all term admissions to SCBU. There were 7 term admissions to SCBU in March, compared to 4 in February. The average number per month over the last 12 months is 6.

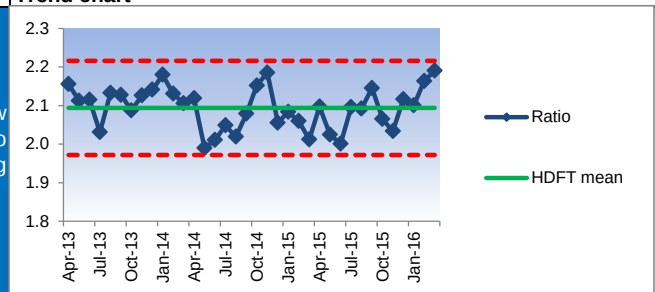
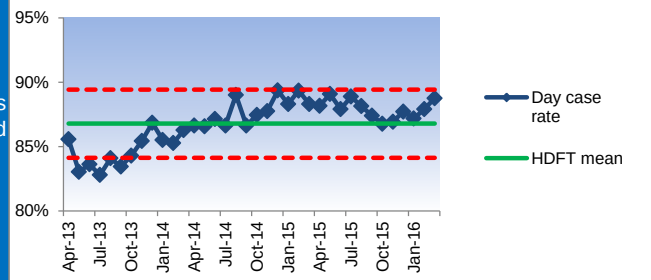
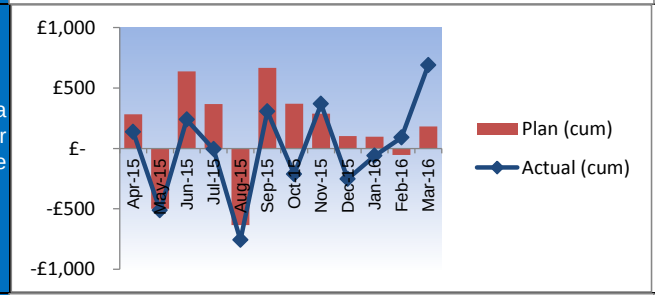
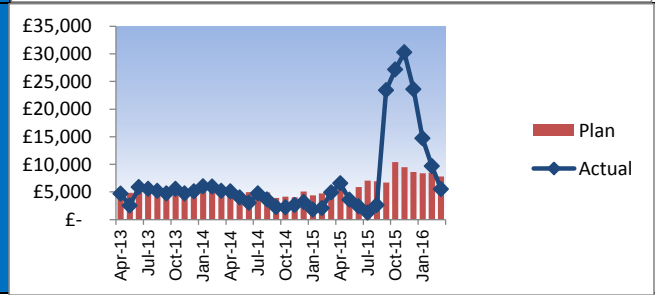
Finance and Efficiency - March 2016

Indicator	Description	Trend chart	Interpretation
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.		The number of readmissions decreased in February, both actual numbers and as a percentage of all emergency admissions. However this is still higher than the average number of emergency readmissions last year. As part of CQUINs, a further case note audit of January and February readmissions is being undertaken and any themes identified, actions drawn up and implemented.
Readmissions - standardised	This indicator looks at the standardised readmission rate within 30 days. The data is standardised against various criteria including age, sex, diagnosis, comorbidites etc. The standardisation enables a more like for like comparison with other organisations. The national average is set at 100. A low rate is good - rates below 100 indicate a lower than expected readmission rate and rates above 100 indicate higher than expected readmission rate.		We have amended the presentation of this indicator this month to show a 12 month rolling average position. HDFT's standardised readmission rate for the 12 month period ending December 2015 was 101.2 - above the national average but within expected levels.
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.		The average elective length of stay for March was 3.4 days, an increase on the previous month. A focus on sustainably reducing this through the Planned Care Transformation programme is underway, which includes reducing the number of patients admitted the day before surgery. Two average lines have been added to the chart (national average and the average for a group of similar benchmarked trusts). These will enable us to understand where HDFT sit and whether our actions have an impact compared to other Trusts.
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.		The average non-elective length of stay for March was 4.8 days, a decrease on the previous month. Two average lines have been added to the chart (national average and the average for a group of similar benchmarked trusts). These will enable us to understand where HDFT sit and whether our actions have an impact compared to other Trusts.

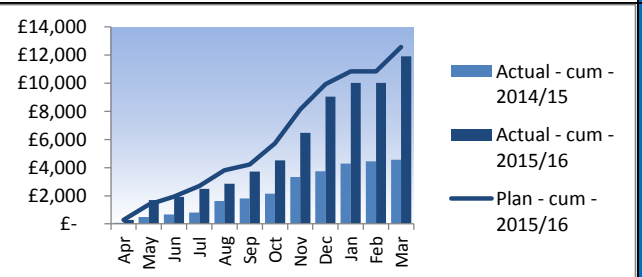
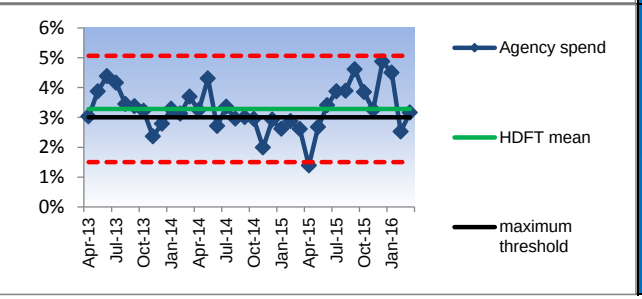
Finance and Efficiency - March 2016

Indicator	Description	Trend chart	Interpretation
Non-elective bed days	The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. A lower figure is preferable.		As can be seen, the number of non-elective bed days for patients aged 18+ has remained fairly static over the last two years. Further analysis of this new indicator will be completed to look at the demograghic changes during this period and the number of admissions for this group will assist in understanding this further. This is also the focus of the New Care Models work and one of the metrics being used to evaluate this pilot.
Theatre utilisation	The percentage of time utilised during elective theatre sessions only (i.e. those planned in advance for waiting list patients). A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.		Theatre utilisation increased to 86.3% in March. The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of this. As can be seen, the number of cancelled sessions in February was high - however this was due to planned theatre maintenance in both main theatres and day surgery unit which was arranged alongside clinician annual leave.
Delayed transfers of care	The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable. A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG.		Delayed transfers of care reduced to 1.5% when the snapshot was taken in March, below the maximum threshold of 3.5% set out in the contract.
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.		The DNA rate was 4.2% in March, no significant change on recent months. DNA rates at outreach clinics continue to be monitored to ensure that they are not significantly higher than clinics on the main site. During Q4, the DNA rate for first outpatient appointments at outreach clinics reduced from 5.1% to 4.7%, but remains above the DNA rate on the main Harrogate site (4.4%).

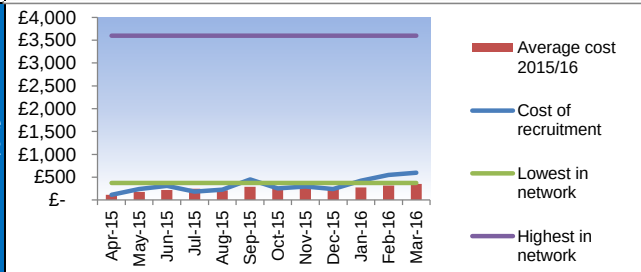
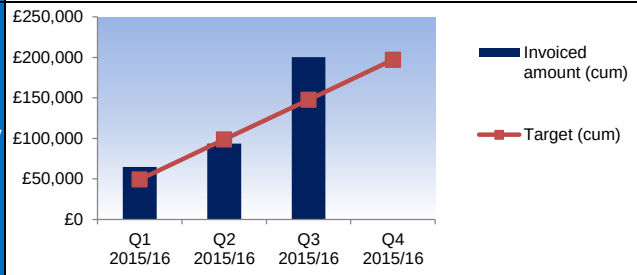
Finance and Efficiency - March 2016

Indicator	Description	Trend chart	Interpretation
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.		Actions with HARD CCG continue and are on plan.
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.		The Day Surgery Transformation group continues their work and are on plan.
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.		The Trust reported an underlying surplus for 2015/16 of £27k, £1,773k behind plan.
Cash balance	Monthly cash balance (£'000s)		The Trust year end cash balance was £5.5m. This is £2.2m behind plan. Although this could be linked to the Trust's financial performance, there is a significant number of outstanding debts. Work is being undertaken to address this. It should also be noted that the Trust is yet to invoice Harrogate and Rural District CCG for £3.8m in relation to the 2015/16 overtrade.

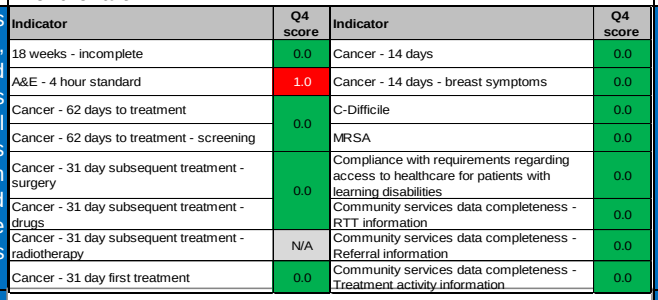
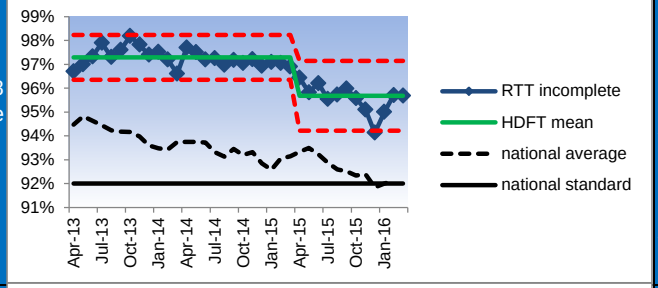
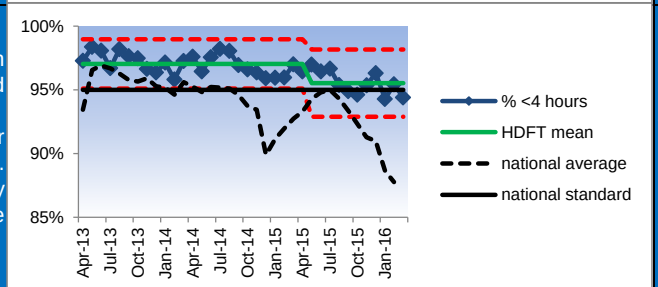
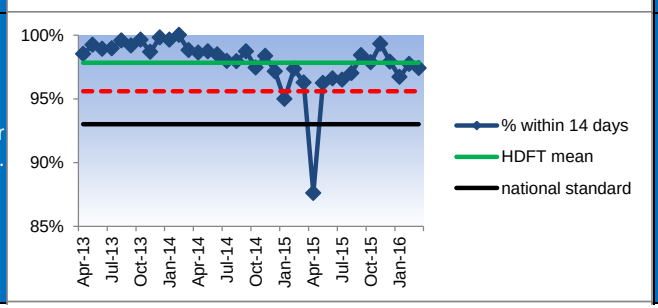
Finance and Efficiency - March 2016

Indicator	Description	Trend chart	Interpretation
Monitor continuity of services risk rating	The Monitor Continuity of Services (CoS) risk rating now includes four components, as illustrated in the table to the right. An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.	<table><tr><th>Element</th><th>Plan</th><th>Actual</th></tr><tr><td>Capital Service Capacity rating</td><td>4</td><td>3</td></tr><tr><td>Liquidity rating</td><td>4</td><td>4</td></tr><tr><td>I&E Margin rating</td><td>3</td><td>3</td></tr><tr><td>I&E Margin Variance rating</td><td>2</td><td>3</td></tr><tr><td>Financial Sustainabiltiy Risk Rating</td><td>3</td><td>3</td></tr></table>	The Trust will report a risk rating of 3 for the year to March. This is in line with the Trust plan and an improvement on the 3 reported in previous months
CIP achievement	Cost Improvement Programme (CIP) performance outlines full year achievement on a monthly basis. The target is set at the internal efficiency requirement (£'000s). This indicator monitors our year to date position against plan.		The Trust achieved the 2015/16 CIP target non recurrently. This is an excellent achievement as a result of a significant effort across the Trust.
Capital spend	Cumulative Capital Expenditure by month (£'000s)		Trust capital expenditure was £11,914k for 2015/16. Although this was below the initial plan, the actual resources available reduced due to the Trust's financial position. Work was undertaken with the Clinical Directorates in Q3 and Q4 to manage capital expenditure and identify schemes which could be carried over into 2016/17. In total, £950k of capital schemes were carried over.
Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis as a percentage of total pay bill. The Trust aims to have less than 3% of the total pay bill on agency staff.		The agency bill for March was 3.16% of Trust pay expenditure. Detailed work is ongoing with Clinical Directorates to reduce total agency spend and ensure compliance with the agency cap.

Finance and Efficiency - March 2016

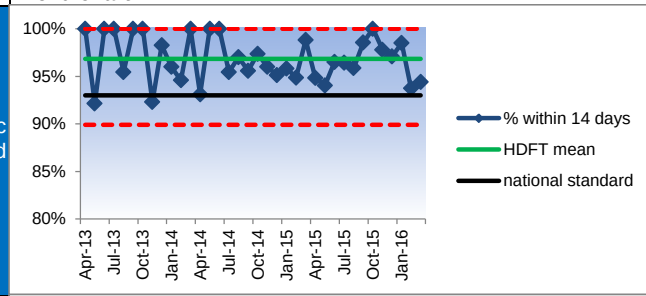
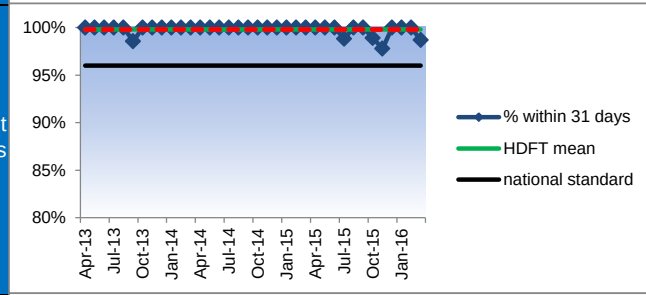
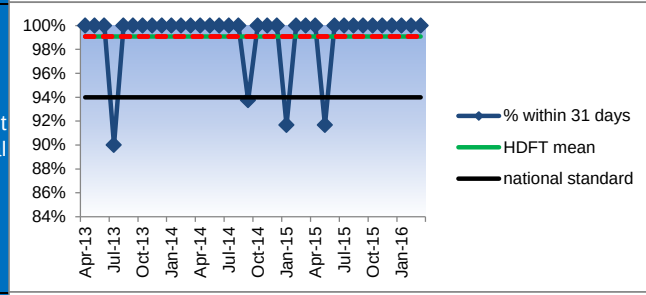
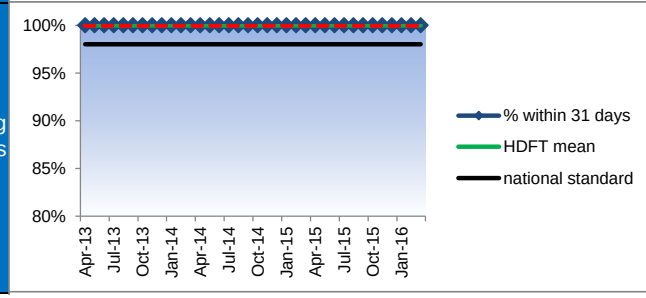
Indicator	Description	Trend chart	Interpretation
Research - Cost per recruitment	Cost of recruitment to NIHR adopted studies. The Research department has a delivery budget of £69,212 per month. A low figure is preferable.		The Research department has a delivery budget of £69,212 per month. The Yorkshire and Humber Clinical Research Network calculate the cost of recruitment at each NHS site. It is desired that HDFT return a cost of recruitment that is in line with previous years.
Research - Invoiced research activity	Aspects of research studies are paid for by the study sponsor or funder.		As set out in the Research & Development strategy, the Trust intends to maintain its current income from commercial research activity and NIHR income to support research staff to 2019. Each study is unique. Last year the Trust invoiced for a total of £223k. Data for Q4 will be reported in next month's report.

Operational Performance - March 2016

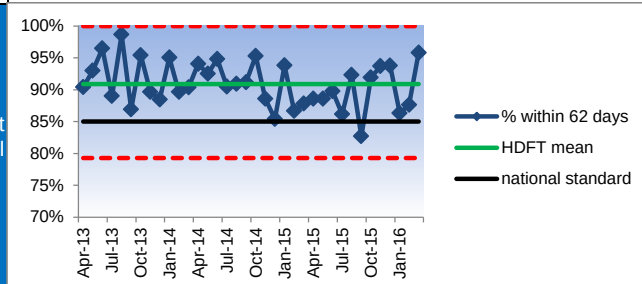
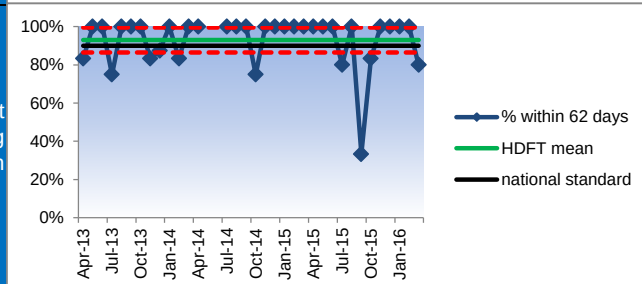
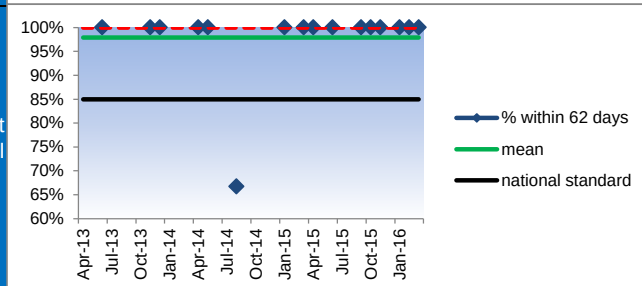
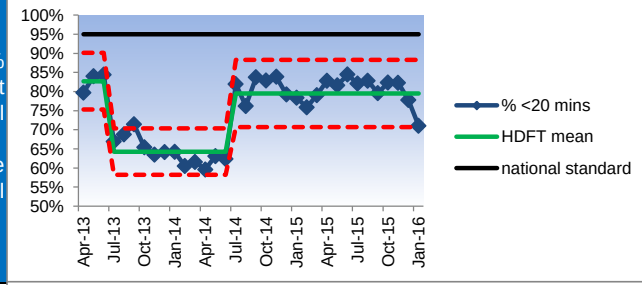
Indicator	Description	Trend chart	Interpretation
Monitor governance rating	Monitor use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the left shows how the Trust is performing against the national performance standards in the "access and outcomes metrics" section of the Risk Assessment Framework. An amended Risk Assessment Framework was published by Monitor in August 2015 - updated to reflect the changes in the way that the 18 weeks standard is monitored.		HDFT's governance rating for Q4 is Green. The Trust's performance against the A&E 4 hour standard was below 95% for Q4. However this does not affect the Trust's overall governance rating as long as the Trust reports performance above the 95% standard next quarter. The Trust reported 34 cases of hospital acquired C. difficile in 2015/16. RCA results indicate that 23 of these cases were not due to lapses in care and therefore these would be discounted from the trajectory for 2015/16. 4 cases are still under RCA.
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.		95.7% of patients were waiting 18 weeks or less at the end of March, no change on last month with performance remaining above the required national standard of 92%. At specialty level, Trauma & Orthopaedics performance has deteriorated and was below the 92% standard in March. Concern remains about sustaining performance for this specialty, particularly in light of the new agency cap from 1st April and the impact it has on theatre staffing.
A&E 4 hour standard	Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%. The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good. Historical data for HDFT included both Ripon and Selby MIUs. In agreement with local CCGs, York NHSFT are reporting the activity for Selby MIU from 1st May 2015.		HDFT's overall Trust level performance for March 2016 was 94.4%, below the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Q4 overall is also below 95%. Further information is provided on this performance position in the Chief Operating Officer's report.
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.		Delivery at expected levels.

Indicator	Q4 score	Indicator	Q4 score
18 weeks - incomplete	0.0	Cancer - 14 days	0.0
A&E - 4 hour standard	1.0	Cancer - 14 days - breast symptoms	0.0
Cancer - 62 days to treatment	0.0	C-Difficile	0.0
Cancer - 62 days to treatment - screening		MRSA	0.0
Cancer - 31 day subsequent treatment - surgery	0.0	Compliance with requirements regarding access to healthcare for patients with learning disabilities	0.0
Cancer - 31 day subsequent treatment - drugs		Community services data completeness - RTT information	0.0
Cancer - 31 day subsequent treatment - radiotherapy	N/A	Community services data completeness - Referral information	0.0
Cancer - 31 day first treatment	0.0	Community services data completeness - Treatment activity information	0.0

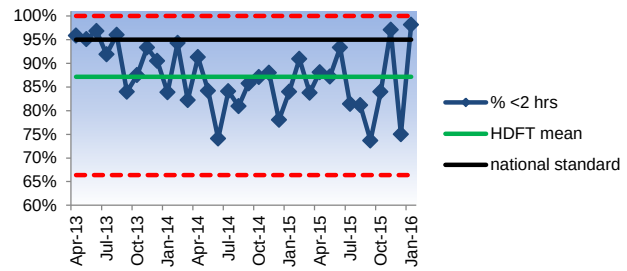
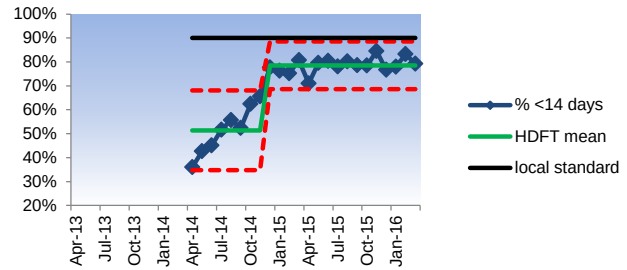
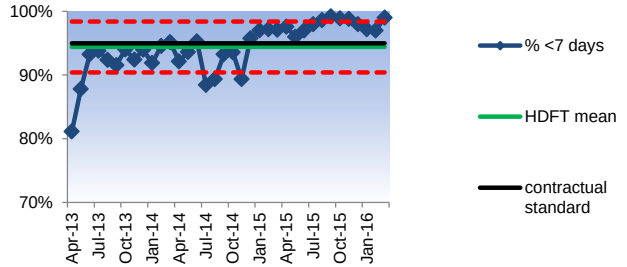
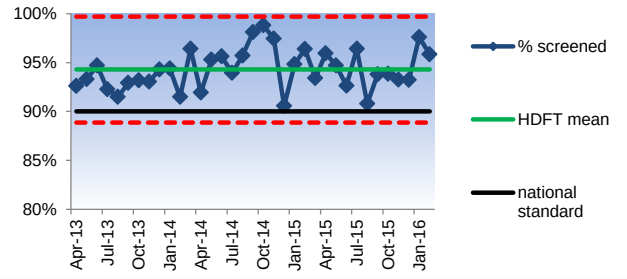
Operational Performance - March 2016

Indicator	Description	Trend chart	Interpretation
Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good.		Delivery of the 93% standard remains challenging due to increased demand on the service. However, the Clinical Directorates worked well together to achieve this in February and March.
Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good.		Delivery at expected levels.
Cancer - 31 day wait for second or subsequent treatment: Surgery	Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good.		Delivery at expected levels.
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good.		Delivery at expected levels.

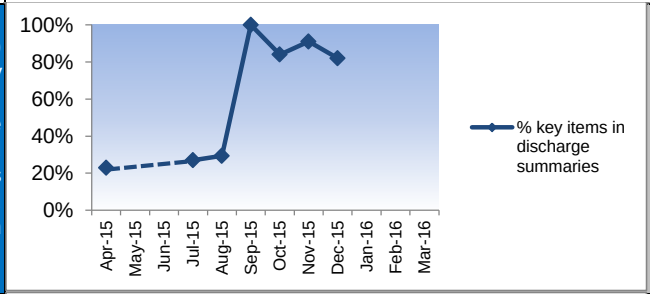
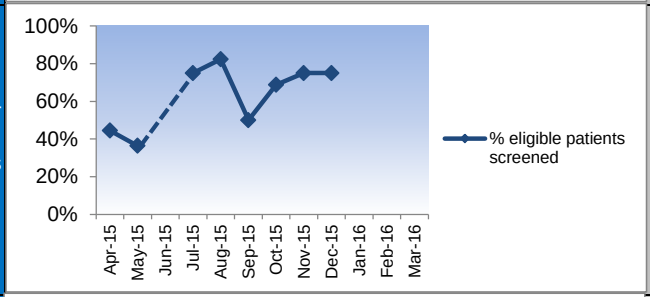
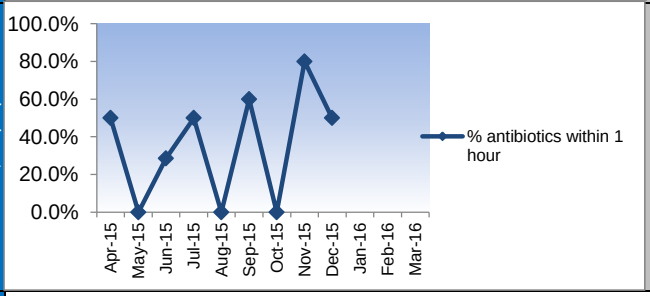
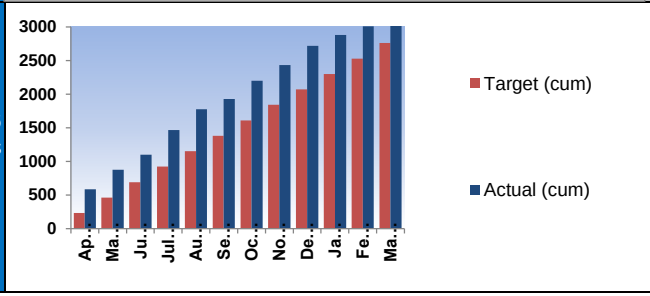
Operational Performance - March 2016

Indicator	Description	Trend chart	Interpretation
Cancer - 62 day wait for first treatment from urgent GP referral to treatment	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.		Trust total delivery at expected levels. Of the 11 cancer sites treated at HDFT, 2 had performance below 85% - gynaecological (0.5 breach) and head and neck (1 breach). One patient waited over 104 days for treatment in March. This was due to clinical complexity and patient choice.
Cancer - 62 day wait for first treatment from consultant screening service referral	Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good.		Delivery at expected levels.
Cancer - 62 day wait for first treatment from consultant upgrade	Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good.		Delivery at expected levels.
GP OOH - NQR 9	NQR 9 (National Quality Requirement 9) looks at the % of GP OOH telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation. The data presented excludes Selby and York as these do not form part of the HDFT OOH service from April 2015. A high percentage is good.		*There is no update of this data this month.* The Trust recently changed the way that some patient groups are managed within the GP OOH service to improve efficiency and patient experience. Reports from the Adastra system no longer calculate the correct start time for these patients and as a result, the performance reported for some of the NQRs is now incorrect. We have been working with YAS to resolve this and have made some progress but are not yet confident that the data reported accurately reflects performance. The recent problems with the data have reiterated that the NQRs are out of date. We are proposing revised metrics which more comprehensively reflect both the quality and responsiveness of the GP OOH service.

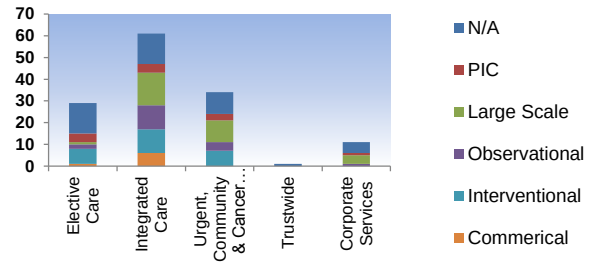
Operational Performance - March 2016

Indicator	Description	Trend chart	Interpretation
GP OOH - NQR 12	NQR 12 (National Quality Requirement 12) looks at the % of GP OOH face to face consultations (home visits) started for urgent cases within 2 hours. The data presented excludes Selby and York as these do not form part of the HFT OOH service from April 2015. A high percentage is good.		*There is no update of this data this month.* The Trust recently changed the way that some patient groups are managed within the GP OOH service to improve efficiency and patient experience. Reports from the Adastra system no longer calculate the correct start time for these patients and as a result, the performance reported for some of the NQRs is now incorrect. We have been working with YAS to resolve this and have made some progress but are not yet confident that the data reported accurately reflects performance. The recent problems with the data have reiterated that the NQRs are out of date. We are proposing revised metrics which more comprehensively reflect both the quality and responsiveness of the GP OOH service.
Health Visiting - new born visits	The number of babies who had a new born visit by the Health Visiting team within 14 days of birth. Data is not available for 2013/14. A high percentage is good.		In March, 79% of babies had a new born visit within 14 days of birth, remaining below the 95% standard. As can be seen from the chart, the performance on this metric improved significantly during 2014/15 - this was partly due to improved data capture over this period.
Community equipment - deliveries within 7 days	The number of standard items delivered within 7 days by the community equipment service. A high percentage is good.		Performance above expected levels.
CQUIN - dementia screening	The proportion of emergency admissions aged 75 or over who are screened for dementia within 72 hours of admission (Step 1). Of those screened positive, the proportion who went on to have an assessment and onward referral as required (Step 2 and 3). The operational standard is 90% for all 3 steps. A high percentage is good.		Recurrent achievement of this standard. Ongoing monitoring. No new actions identified. It is anticipated that the Trust will achieve this CQUIN for Q4.

Operational Performance - March 2016

Indicator	Description	Trend chart	Interpretation
CQUIN - Acute Kidney Injury	Percentage of patients with Acute Kidney Injury (AKI) whose discharge summary includes four defined key items. The aim of this national CQUIN is to improve the provision of information to GPs for patients diagnosed with AKI whilst in hospital. The target for the CQUIN is to achieve at least 90% of required key items included in discharge summaries by Q4 2015/16. A high percentage is good.		*There is no update on this data this month. Data for Q4 will be presented in April's report.* It is anticipated that the Trust will achieve this CQUIN for Q4.
CQUIN - sepsis screening	Percentage of patients presenting to ED/other wards/units who met the criteria of the local protocol and were screened for sepsis. A high percentage is good.		*There is no update on this data this month. Data for Q4 will be presented in April's report.* There has been significant in-year improvement in the screening of patients. However the full year achievement of this CQUIN remains challenging.
CQUIN - severe sepsis treatment	Percentage of patients presenting to ED/other wards/units with severe sepsis, Red Flag Sepsis or Septic Shock and who received IV antibiotics within 1 hour of presenting. A high percentage is good.		*There is no update on this data this month. Data for Q4 will be presented in April's report.* The in-year fluctuations in performance reflect the very low numbers of patients which fall within this requirement. The full year delivery of this CQUIN will be challenging.
Recruitment to NIHR adopted research studies	The Trust has a recruitment target of 2,750 for 2015/16 for studies adopted onto the NIHR portfolio. This equates to 230 per month. A higher figure is good.		Recruitment has been good to date. Currently recruitment stands at 365 over its target year to date. The department currently has an online study which recruits very well - 48% of recruits in 2015/16 have been via this route.

Operational Performance - March 2016

Indicator	Description	Trend chart	Interpretation
Directorate research activity	The number of studies within each of the directorates - included in the graph is Trustwide where the study spans directorates. The Trust has no specific target set for research activity within each directorate. It is envisaged that each clinical directorate would have a balanced portfolio.		The directorate research teams are subject to studies that are available to open. The 'type of study', Commercial, Interventional, Observational, Large scale, Patient Identification Centre (PIC) or N/A influence the activity based funding received by HDFT. Each category is weighted dependant on input of staff involvement. N/A studies are those studies which are not on the NIHR portfolio. They include commercial, interventional, observational, large scale, PIC, local and student projects. They do not influence the recruitment target.

Indicator traffic light criteria

Section	Indicator	Further detail	Proposed traffic light criteria	Rationale/source of traffic light criteria
Quality	Safety thermometer - harm free care	% harm free	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%.
Quality	Pressure ulcers - hospital acquired	No. grade 3 and grade 4 avoidable hospital acquired pressure ulcers	Green if no. avoidable cases is below local trajectory year to date, red if above trajectory year to date.	A maximum threshold of 14 avoidable cases during 2015/16 has been locally agreed. This reflects a 50% reduction on last year's figure.
Quality	Pressure ulcers - community acquired	No. grade 3 and grade 4 community acquired pressure ulcers	tbc	tbc
Quality	Falls	IP falls per 1,000 bed days	Blue if YTD position is a reduction of <=50% of HDFT average for 2014/15, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2014/15, Amber if YTD position is a reduction of up to 20% of HDFT average for 2014/15, Red if YTD position is on or above HDFT average for 2014/15.	
Quality	Falls causing harm	IP falls causing moderate harm, sever harm or death, per 1,000 bed days		Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	Infection control	No. hospital acquired C.diff cases	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, Monitor and contractual requirement
Quality	Avoidable admissions	The number of avoidable emergency admissions to HDFT as per the national definition.	tbc	tbc
Quality	Reducing readmissions in older people	The proportion of older people 65+ who were still at home 91 days after discharge from hospital into rehabilitation or reablement services.	tbc	tbc
Quality	Mortality - HSMR	Hospital Standardised Mortality Ratio (HSMR)	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	
Quality	Mortality - SHMI	Summary Hospital Mortality Index (SHMI)		Comparison with national average performance.
Quality	Complaints	No. complaints, split by criteria	Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2014/15, Amber if above HDFT average for 2014/15, Red if above UCL. In addition, Red if a new red rated complaint received in latest month.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	Incidents - all	Incidents split by grade (hosp and community)	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
Quality	Incidents - SIRIs and never events	SIRI and never events (hosp and community)	Green if latest month =0, red if latest month >0.	
Quality	Friends & Family Test (FFT) - Staff	% staff who would recommend HDFT as a place to work	Blue if latest month score places HDFT in the top 10% of acute trusts nationally and/or the % staff recommending the Trust is above 95%, Green if in top 25% of acute trusts nationally, Amber if within the middle 50%, Red if in bottom 25%.	
Quality	Friends & Family Test (FFT) - Staff	% staff who would recommend HDFT as a place to receive care		Comparison with performance of other acute trusts.
Quality	Friends & Family Test (FFT) - Patients	% recommend, % not recommend - combined score for all services currently doing patient FFT	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
Quality	Safer staffing levels	RN and CSW - day and night overall fill rates at trust level	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
Quality	Staff appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months	Annual rolling total - 85% green. Amber between 70% and 85%, red<70%.	Locally agreed target level based on historic local and NHS performance
Quality	Mandatory training rate	Latest position on the % staff trained for each mandatory training requirement	Blue if latest month >=95%; Green if latest month 75%-95% overall, amber if between 50% and 75%, red if below 50%.	Locally agreed target level - no national comparative information available until February 2016
Quality	Staff sickness rate	Staff sickness rate	Green if <3.9% , amber if between 3.9% and regional average, Red if > regional average.	HDFT Employment Policy requirement. Rates compared at a regional level also
Quality	Temporary staffing expenditure - medical/nursing/other	Expenditure per month on staff types.	tbc	tbc
Quality	Staff turnover	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
Quality	Research internal monitoring	No. critical or major findings reported	Green if <1 per quarter (cumulative)	Locally agreed target.
Quality	Maternity - Caesarean section rate	Caesarean section rate as a % of all deliveries	Green if <25% of deliveries, amber if between 25% and 30%, red if above 30%.	tbc
Quality	Maternity - Rate of third and fourth degree tears	No. third or fourth degree tears as a % of all deliveries	Green if <3% of deliveries, amber if between 3% and 6%, red if above 6%.	tbc
Quality	Maternity - Unexpected term admissions to SCBU	Admissions to SCBU for babies born at 37 weeks gestation or over.	tbc	tbc
Finance and efficiency	Readmissions	No. emergency readmissions (following elective or non-elective admission) within 30 days.	Green if latest month < HDFT average for 2014/15, Red if latest month > HDFT average for 2014/15.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Finance and efficiency	Readmissions - standardised	Standardised emergency readmission rate within 30 days from HED	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
Finance and efficiency	Length of stay - elective	Average LOS for elective patients	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	
Finance and efficiency	Length of stay - non-elective	Average LOS for non-elective patients		Comparison with performance of other acute trusts.

Section	Indicator	Further detail	Proposed traffic light criteria	Rationale/source of traffic light criteria
Finance and efficiency	Non-elective bed days for patients aged 18+	Non-elective bed days at HDFT for HARD CCG patients aged 18+, per 100,000 population	Improvement trajectory to be agreed.	Improvement trajectory to be agreed.
Finance and efficiency	Theatre utilisation	% of theatre time utilised for elective operating sessions	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.
Finance and efficiency	Delayed transfers of care	% acute beds occupied by patients whose transfer is delayed - snapshot on last Thursday of the month.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement
Finance and efficiency	Outpatient DNA rate	% first OP appointments DNA'd	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Finance and efficiency	Outpatient new to follow up ratio	No. follow up appointments per new appointment.		
Finance and efficiency	Day case rate	% elective admissions that are day case		
Finance and efficiency	Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s)	Green if on plan, amber <1% behind plan, red >1% behind plan	Locally agreed targets.
Finance and efficiency	Cash balance	Monthly cash balance (£'000s)	Green if on plan, amber <10% behind plan, red >10% behind plan	Locally agreed targets.
Finance and efficiency	Monitor continuity of services risk rating	The Monitor Continuity of Services (CoS) risk rating is made up of two components - liquidity and capital service cover.	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 Monitor
Finance and efficiency	CIP achievement	Cost Improvement Programme performance	Green if achieving stretch CIP target, amber if achieving standard CIP target, red if not achieving standard CIP target.	Locally agreed targets.
Finance and efficiency	Capital spend	Cumulative capital expenditure	Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan	Locally agreed targets.
Finance and efficiency	Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis (£'s).	Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill.	Locally agreed targets.
Finance and efficiency	Research - Cost per recruitment	Cost of recruitment to NIHR adopted studies	Green if on or above plan, amber if less than 10% behind plan YTD, red if > 10% behind plan YTD.	Locally agreed targets.
Finance and efficiency	Research - Invoiced research activity		to be agreed	
Operational Performance	Monitor governance rating	Trust performance on Monitor's risk assessment framework.	As per defined governance rating	as defined by Monitor
Operational Performance	RTT Incomplete pathways performance	% incomplete pathways within 18 weeks	Green if latest month >=92%, Red if latest month <92%.	NHS England
Operational Performance	A&E 4 hour standard	% patients spending 4 hours or less in A&E.	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	NHS England, Monitor and contractual requirement of 95% and a locally agreed stretch target of 97%.
Operational Performance	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	% urgent GP referrals for suspected cancer seen within 14 days.	Green if latest month >=93%, Red if latest month <93%.	NHS England, Monitor and contractual requirement
Operational Performance	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	% GP referrals for breast symptomatic patients seen within 14 days.	Green if latest month >=93%, Red if latest month <93%.	NHS England, Monitor and contractual requirement
Operational Performance	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	% cancer patients starting first treatment within 31 days of diagnosis	Green if latest month >=96%, Red if latest month <96%.	NHS England, Monitor and contractual requirement
Operational Performance	Cancer - 31 day wait for second or subsequent treatment: Surgery	% cancer patients starting subsequent surgical treatment within 31 days	Green if latest month >=94%, Red if latest month <94%.	NHS England, Monitor and contractual requirement
Operational Performance	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	% cancer patients starting subsequent anti-cancer drug treatment within 31 days	Green if latest month >=96%, Red if latest month <96%.	NHS England, Monitor and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	% cancer patients starting first treatment within 62 days of urgent GP referral	Green if latest month >=85%, Red if latest month <85%.	NHS England, Monitor and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from consultant screening service referral	% cancer patients starting first treatment within 62 days of referral from a consultant screening service	Green if latest month >=90%, Red if latest month <90%.	NHS England, Monitor and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from consultant upgrade	% cancer patients starting first treatment within 62 days of consultant upgrade	Green if latest month >=85%, Red if latest month <85%.	NHS England, Monitor and contractual requirement
Operational Performance	GP OOH - NQR 9	% telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation	Green if latest month >=95%, Red if latest month <95%.	Contractual requirement
Operational Performance	GP OOH - NQR 12	% face to face consultations started for urgent cases within 2 hours	Green if latest month >=95%, Red if latest month <95%.	Contractual requirement
Operational Performance	Health Visiting - new born visits	% new born visit within 14 days of birth	Green if latest month <=95%, Amber if between 90% and 95%, Red if <90%.	Contractual requirement
Operational Performance	Community equipment - deliveries within 7 days	% standard items delivered within 7 days	Green if latest month >=95%, Red if latest month <95%.	Contractual requirement
Operational Performance	CQUIN - dementia screening	% emergency admissions aged 75+ who are screened for dementia within 72 hours of admission	Green if latest month >=90%, Red if latest month <90%.	CQUIN contractual requirement
Operational Performance	CQUIN - Acute Kidney Injury (AKI)	% patients with AKI whose discharge summary includes four defined key items	to be agreed with CCG during Q2 2015/16	CQUIN contractual requirement
Operational Performance	CQUIN - sepsis screening	% patients presenting to ED/other wards/units who met the criteria of the local protocol and were screened for sepsis	to be agreed with CCG during Q2 2015/16	CQUIN contractual requirement
Operational Performance	CQUIN - severe sepsis treatment	% patients presenting to ED/other wards/units with severe sepsis, Red Flag Sepsis or Septic Shock and who received IV antibiotics within 1 hour of presenting	to be agreed with CCG during Q2 2015/16	CQUIN contractual requirement
Operational Performance	Recruitment to NIHR adopted research studies	No. patients recruited to trials	Green if above or on target, red if below target.	
Operational Performance	Directorate research activity	The number of studies within each of the directorates	to be agreed	

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Harrogate and District NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS: **18 May 2016**

Report Title: **Tender for External Auditors**

Report From: **Mr Jonathan Coulter, Deputy Chief Executive/Finance Director**

Report Purpose: **To consider and approve the process for the appointment of the External Auditor highlighted in section 6.**

1. Introduction

Harrogate and District NHS Foundation Trust (HDFT) was awarded Foundation Trust status on 1 January 2005; this allowed the Trust to select its own external auditors. HDFT commenced a tender process for the first time for the accounting year 2006/07, the end result of that tender process was the Trust's Governors appointment of the Audit Commission (Trust Practice).

The Trust for the accounting year 2011/12 then tendered again the end result of that tender process was the Trust's Governors appointment of KPMG.

On both occasions the appointments were for a primary term of three years with an option to extend into secondary terms of a further two years. At the end of both three year primary terms HDFT, through the Audit Committee, reviewed the effectiveness of the incumbent External Auditor and recommended to the Trust's Governors approval of entering into the secondary terms; these were approved.

The Trust shortly needs to commence a tender process to facilitate the Governors' appointment of external auditors for the accounting year 2016/17 and beyond.

2. Development of a Process

The Trust used an NHS Commercial Procurement Collaborative (CPC) framework agreement for the appointment of KPMG. Use of framework agreements are the preferred route for procurements as they offer value for money (VFM); they also all significantly reduce the risk of legal challenges.

The framework utilised for the appointment of KPMG has now expired, however the North of England (NoE) CPC has launched a replacement external audit framework which had a go live date of 12 February 2016.

The NoE has offered (as a member of the collaborative) the use of their e-tendering portal "In-Tend". The portal would issue the Invitation to Tender (ITT) documents, funnelling any clarification questions via the portal to the Trust and would ultimately issue the award/decline letters.

3. NoE CPC Proposed Procurement Timetable

Technically the current contract with KPMG expires upon discharge of their duty to report the findings from the accounting year 2015/16 to the Governors at the meeting of 3 August 2016. The NoE CPC have provided a draft timeline that we could work to below (without specific dates):

Milestone	Date
Competition documents issued	
Deadline for responses	+ 3 weeks
Evaluation (remotely via In-tend)	+ 2 weeks
Moderation (optional)	+ 1 week
Contract award	
Voluntary Standstill period	+ 10 days
Contract start date from	

4. HDFT Proposed Procurement Timetable

The following HDFT timetable is proposed.

Milestone	Draft Dates
Invite bidders to submit proposals for consideration (issue documents).	Week commencing 18 July 2016
Deadline for responses	Week commencing 8 August 2016
Opportunity for bidders to visit the Trust (fact finding etc).	Week commencing 22 August 2016
Finance Director led assessment of submitted documents (Evaluation).	Week commencing 29 August 2016
Presentations to the Auditor Selection Panel (Evaluation/Moderation).	9 September 2016
Decision ratified by: • Board of Directors • Council of Governors	 26 October 2016 2 November 2016
Contract award	2 November 2016
Voluntary Standstill Period	2 November 2016
Contract Start Date	16 November 2016

5. Auditor Selection Panel

The proposed selection panel are:

Chair:	Deputy Chair of the Council of Governors
	Governors (2)
	Audit Committee Chairman
	Audit Committee Member(s)
	Deputy Finance Director
	Finance Director/Deputy Chief Executive
	Company Secretary

6. Action required

I request the Governors to note the contents of this paper and:

- Approve using the NHS CPC procurement framework which has been developed to reduce costs and risks.

- Approve HDFT proposed procurement timetable and the establishment of the Auditor Selection Panel.

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Paper 14.1

Harrogate and District NHS
NHS Foundation Trust

ANNUAL MEMBERS' MEETING – 2014/15

The third Annual Members' Meeting of the Harrogate and District NHS Foundation Trust (HDFT) was held on Thursday 3 September 2015 at 6:00 pm in the Aire Room, The Pavilions, Wetherby Road, Harrogate.

Present

Governors	
Pamela Allen, Public Governor	Carol Cheesebrough, Staff Governor
Michael Armitage, Public Governor	Emma Edgar, Staff Governor
Cath Clelland, Public Governor	Sally Margerison, Staff Governor
Liz Dean, Public Governor	Dr Daniel Scott, Staff Governor
Jane Hare, Public Governor	Fiona Wilson, Staff Governor
Pat Jones, Public Governor	Bernard Bateman, Stakeholder Governor
Peter Pearson, Public Governor	Sarah Crawshaw, Stakeholder Governor
Rev Dr Mervyn Willshaw, Public Governor	

In attendance	
Sandra Dodson, Chairman	Neil McLean, Non-Executive Director
Dr Ros Tolcher, Chief Executive	Sue Proctor, Non-Executive Director
Jonathan Coulter, Director of Finance	Chris Thompson, Non-Executive Director
Jill Foster, Chief Nurse	Lesley Webster, Non-Executive Director
Robert Harrison, Chief Operating Officer	Ian Ward, Non-Executive Director
Dr David Scullion, Medical Director	Dr Natalie Lyth, Clinical Director
Phillip Marshall, Director of Workforce & OD	David Plews, Deputy Director of Partnerships and Innovation
Joanne Crewe, Operational Director	Karen Barnett, Operational Director
Andrew Forsyth, Interim Head of Corporate Affairs	Angie Colvin, Corporate Affairs and Membership Manager

Members in attendance:
Sue Symington, Pauline Ashfield, Paul Ashfield, John Bashall, , Michael Brown, , Maggie Cowman, Nina Douglas, Anthony Doveston, Richard Eastoe, Anthony Fitzgerald, Amanda Gillespie, David Hall, Michael Harrison, Andrew Hart, Pat Hewitson, Susan Hobbs, Rick Hodgson, Bryan Jones, Barbara Lyon, Rachel Mann, Jillian Miller, Irene Moore, Netty Newall, Rev David Payne, Anne Pearson, Maggie Peat, Sheenagh Powell, Sue Roberts, Dr Rick Sweeney, , Jackie Terry-

Schumann, Frank Ward, Michael Warren, Dr Bruce Willoughby, Andy Wilkinson and Alison Wrigglesworth.

1. Welcome and Apologies for absence

The Chairman, Mrs Sandra Dodson, welcomed all attendees and in particular mentioned Governors, staff, volunteers and partners. She said that the Annual Members' Meeting was always an important opportunity to review what had happened during the year but that this year the format and venue had been changed. The Trust was taking the opportunity to 'continue the conversation' with members and to look back, examine the 'here and now' and look at the future direction of the Trust. Dr Tolcher, the Chief Executive, Mr Coulter, Director of Finance, and Rev Dr Willshaw, the Deputy Chair of Governors, would be supporting the formal parts of the meeting and the review of the past year; Mrs Dodson was also pleased to welcome Dr Bruce Willoughby, Lead for Planned Care, Harrogate and Rural District Clinical Commissioning Group, who was part of the New Models of Care team. There would be time for questions and discussion towards the end of the meeting.

Apologies for absence had been received from:

Sally Blackburn (Public Governor), Andy Robertson (Public Governor), Jane Hedley (Public Governor), Joyce Purkis (Public Governor), John Ennis (Stakeholder Governor), Fiona Wilson (Staff Governor), Joanna Parker (Public Governor), Dr Jim Woods (Stakeholder Governor), Carl Les (NYCC), Wallace Sampson (Harrogate Borough Council), Tony Collins (St Michael's Hospice), Karen Weaver (H & R CVS) Della Cannings (Chairman, YAS), Patrick Crowley (CEO York Teaching Hospital NHS FT), Keith Ramsay (Vale of York CCG), Bridget Fletcher (CEO Airedale NHS Foundation Trust), Nigel Gray (Leeds North CCG), Philip Lewer (Leeds South and East CCG), Fay Scullion (Regional General Manager, Macmillan Cancer Support), Andy Smith (KPMG, Trust Auditors), Alistair Ingram (HaRD CCG), Vicky Pleydell (Hambleton and Richmond CCG), Kathy Clark (NYCC), Andrew Jones MP, Julian Smith MP and a number of members.

2. Chairman's Introduction and Overview – Mrs Sandra Dodson, Chairman.

Mrs Dodson said this meeting was an important opportunity to reflect on what had gone well during the previous year and what had perhaps not gone quite so well. She said that it was also an opportunity for members to engage with Governors, who were well-represented. Dr Tolcher would be leading on 'continuing the conversation' whilst Mr Coulter would present the Annual Report and Accounts of the Trust, as was required by our regulator, Monitor. First, however, she covered three key elements – changes at Board level, transformation of services and the contribution of the Council of Governors.

To paraphrase Oscar Wilde, Mrs Dodson said, to lose one Board member was to be unfortunate but to lose two would be careless. During the year the Board had said farewell to both John Ridings and Sue Symington, who had been very valuable Non-Executive Directors. In their place the Board had welcomed Maureen Taylor and Neil McLean. At the same time Richard Ord, Chief Executive, and Angela Monaghan, Chief Nurse, had both retired and had been replaced by Dr Ros Tolcher and Jill Foster respectively. Mrs Dodson said that the refashioned Board had quickly settled and there was no sign of an unsteady ship.

Turning to transformation, Mrs Dodson said that the Trust had a clear appetite for innovation and transformation of both services themselves and the way in which they were delivered. The Trust had been selected as one of only 29 national Vanguard sites and would be looking at new ways of delivering care, both in the hospital and in the community. Internally there had been a series of Rapid Process Improvement Workshops which had given departments time and space to review, transform and improve services. Sometimes the changes had been both transformational and transactional but always they were steps which would deliver the highest quality care.

The Council of Governors, in Mrs Dodson's view, was a fantastic group of passionate and robust people, and represented the interests of the public and members extremely well. The Trust could not deliver the requirements without their dedication and support – they were the conscience of the Trust. Governors did not run the Trust but they had to be assured that the Board was leading the Trust in the best way possible. The Governors were always keen to listen to members and the wider public and receive feedback about the Trust.

Mrs Dodson said that it was with great sadness that the Council of Governors would be losing Rev Dr Mervyn Willshaw and Fiona Wilson, both of whom would be standing down at the end of the year. It was the natural ebb and flow of a Council of Governors and she thanked them for being stalwarts of the Council, noting that Fiona Wilson had served a full term of nine years.

Mrs Dodson said that there were many number of ways in which members could have conversations with the Trust, be it through writing in when things had gone well and, indeed where this had not been the case, publicly thanking the Trust when appropriate, or speaking directly to Governors or members of staff; she encouraged members to do this as often as possible.

3. Confirmation of Minutes of the Annual General Meeting 2013/14

The minutes of the 2013/14 Annual General Meeting, held on 4 September 2014, had been presented as draft to the Council of Governors' meeting on 29 July 2015. Andy Wilkinson proposed their acceptance as a true record and Fiona Wilson seconded the proposal. There were no objections.

Mrs Dodson reported that the Nominations Committee had met four times during the year, in order to appoint the two new Non-Executive Directors.

Mrs Dodson then introduced the Deputy Chair of the Council of Governors, Rev Dr Mervyn Willshaw, to give the Council of Governors' overview of the year, his last before retiring from the Council.

4. Presentation – Overview of the Year – Reverend Dr Mervyn Willshaw, Deputy Chair of Governors

Rev Dr Willshaw began by saying that this year had been a year of consolidation after many changes in the Council of Governors the previous year due to the ending of terms of office.

As he was always required to do, he opened with some mention of the ways in which the Council had fulfilled some of their statutory duties. He reported one of the first things they had to do during the year was to undertake the appointment process for a Non-Executive Director, which had been unsuccessful first time. This time there was a much stronger field and Mrs Maureen Taylor had been appointed, after many years of valued service to Leeds City Council.

Then had come the news that Sue Symington, Vice-Chair, had been appointed as Chair of the York Teaching Hospital NHS Foundation Trust. Although delighted at her success, but sorry to lose her, the appointment process had begun all over again. Fortunately this time the field had been even stronger than last time and the Governors had been able to make a very good appointment in Neil Maclean. So the Non-Executive Directors were at full strength and was a strong team. He was able to say this with confidence because Governors had enjoyed greater opportunity to see the Non-Executive Directors in action. Governors met with them three times a year to learn more about their particular responsibilities and concerns, saw them regularly at open Board meetings and had a strengthened appraisal system. They were now able to see them in action in the Audit Committee and the Quality Committee, and had increased their engagement with them at Council of Governors' meetings.

A major part of seeking quality assurance was through the Quality of Care Teams where individual Governors were linked with a particular ward or unit of the Trust. The role there was to listen, get to know the staff, learn something of their challenges and successes and, offer members some assurance on quality. Having served in this way now for almost six years, he said that this was one of the most worthwhile and enjoyable things that he had done. Governors also had the opportunity to meet staff and be involved in patient safety visits.

During the year the governance structure of the Trust had been changed so that there was now a Quality Committee running parallel with the Audit Committee

and the Finance Committee. The intention was that there would always be a Governor present to observe and to receive assurance. Two Governors sat on the 'Learning from Patient Experience' group, a sub-committee of the Quality Committee.

Earlier in the year Rev Dr Willshaw and Mrs Colvin had been interviewed by Monitor, the regulatory body, to learn something of the work which Governors do in recruiting and using volunteers and in liaising with local educational institutions. Monitor was sufficiently impressed to feature it in one of their publications for Governors, in the hope that other Trusts might want to do something similar. The Trust had almost 600 volunteers, of whom about 40% were under the age of 25. They worked within the Trust in all sorts of ways from meeting and greeting people in reception to helping with meals, from activity therapy to hairdressing. New ways in which volunteers could contribute to the life of the Trust were constantly being found. The Trust was immensely proud of the volunteers and grateful to them for the time and effort they put in.

Links with schools and colleges had continued as before. During the year 174 students had benefitted from work experience placements. The Membership Development and Communication Group continued to oversee the very popular Medicine for Members' meetings. The Group had produced a newly formatted Foundation News Magazine for members and introduced the orange lanyards for Governors so that they could be more easily identified at events.

A large and active membership was vital to the functioning of the Trust and, whilst there were 17,616 members, that was still only a fraction of the population which this Trust served and more would be welcome. As well as trying to increase the membership, some changes had been made to the agenda of the Council of Governors' meetings, to try and improve engagement with members and one Saturday morning meeting had been held. It had brought in the largest attendance of members and he asked for more ideas for engaging members.

A few minor changes in the Constitution had been made during the year. The Council of Governors had been pleased to welcome three new public Governors during the year - Peter Pearson had been elected and commenced in post in August2014 to represent the Ripon and West District, Cath Clelland had joined in January 2015 to represent the Rest of North Yorkshire and York and following the resignation of Sara Spencer, Liz Dean, had been invited to fill the seat until the next election due in December 2015, as per constitutional and electoral guidelines.

Rev Dr Willshaw said that sadly at the end of the year the Council would lose the services of one of our most stalwart Staff Governors. Fiona Wilson would have completed nine years as a Governor this year and, therefore, had to step down. She had made a tremendous contribution and he thanked her for all she had done.

He went on to say that it was the last occasion on which he would present the report because he would be retiring from the Council in December and he introduced Pamela Allen, who had been elected by the Council as Deputy Chair and Lead Governor and, in commending her to the meeting he said she had all his good wishes as she took over.

Finally he gave a word of thanks to Mrs Dodson and Dr Tolcher and the whole Board for their support, co-operation and friendliness, and to Mrs Colvin for the tremendous help she gave in keeping Governors informed and up-to-speed. He said that they could not operate as Governors without their encouragement and backing.

5. 'What matters to us – continuing the conversation' – Dr Ros Tolcher, Chief Executive

Mrs Dodson introduced Dr Tolcher and said that she would cover the highlights from the last year and give a preview of what was to come.

Dr Tolcher said that this was her second meeting – last year she had been in post for only a month so her perspective was somewhat different this year. She said that she was accountable for providing safe, effective and responsive care for patients and the Annual Members' Meeting was important in terms of accountability. Dr Tolcher said that she was intensely proud of the quality of care provided and of the reputation of the Trust. Her presentation would be in four parts – a look back at a year of exceptional challenge, the national challenges, New Models of Care and the thread of conversation around what matters to members and patients. There would also be a Question and Answer Panel, including a member of the Clinical Commissioning Group.

Dr Tolcher said that the scope of her remarks would not just be the District Hospital but would embrace the community services provided by the Trust across North Yorkshire and the work in north Leeds. The funding for the Trust's services amounted to around £186m per year and applied across a catchment of around 600,000 people. Feedback from patients had been positive, placing the Trust once again in the top 10 Trusts nationally, third in the national cancer patient survey (and top in Yorkshire and Humber) and 12th amongst Emergency Departments. She paid tribute to the work of the staff who had been attaining the highest standards of quality of care. The results of the National Staff Survey demonstrated that 75% of the results were above average. However, Dr Tolcher emphasised that there was no hint of complacency and that the Trust would continue to strive to do better.

In terms of performance, Dr Tolcher was pleased to report a sea of green on those issues which were most important to the Trust's patients. In terms of meeting the Emergency Department waiting time target the Trust had achieved

above 95% in all four quarters and had reported an average of 95% harm free in the Safety Thermometer. Safer staffing data reported registered nurse staffing levels on the wards at around 100%. Care support workers staffing levels had increased, particularly at night, reflective of the increased need for 1:1 care for some inpatients.

The Trust had scored above national average in the staff Friends & Family Test and continued to roll out the patient Friends & Family Test to more services. Elective admissions during 2014/15 had been 9.5% higher than in 2013/14, including a 20.1% increase in activity from Leeds. A relatively small increase in follow-up appointments (2.4%) in the context of a 4.7% overall increase in new appointments had been evidence of the Trust's commitment to improving follow-up ratios. Community services had also experienced significant growth in demand with a 12% increase in District Nursing activity for the period October to March when compared with the same period last year.

Turning to the financial position she believed the glass to be half-full rather than half-empty. The Trust had achieved a small surplus, in contrast to most Trusts, and had no deficit. Over the period of the year it had reported green for both continuity of services and governance. However, it would be important to generate a larger surplus, as had been the case regularly over the previous ten years, to fund capital and service improvements.

Dr Tolcher commended the efforts of the staff, who had been amazing at every level and very focused on delivering high quality care. She added that the volunteers, Non-Executive Directors and Governors provided inspiration and thanked them all.

Moving to the national challenges and local solutions, Dr Tolcher said that there were significant gaps in recruiting the workforce but there was assurance that it would happen. There was a strong indication for and movement towards more integration of services. Simon Stevens, the Chief Executive of the NHS, had highlighted the health and wellbeing gap, the finance and funding gap and the care and quality gap as being three major elements requiring renewed focus. Nationally the NHS finances had an aggregated deficit of £822m at the end of the 2014-15 financial year and the forecast deficit at the end of the current year was £2.1bn. She showed a slide showing the growing funding gap and emphasised the need to do more with less, move forward with seven day working and ensure that New Models of Care all contributed to future sustainability.

Dr Tolcher said that she was keen to continue the conversation that had been started the previous May. By way of overview she said that the bed audit had shown that one in five admissions had probably been clinically avoidable and that 60% of those patients in hospital beds could have had their needs met outside the hospital. She said that the Trust's strategy was to ensure that the people of Harrogate and Rural Districts received high quality affordable healthcare, and

played an active role in making decisions about their own health. The aim was to ensure more people stayed healthier and independent for longer, have choice and control over their lives and care, and that costs were reduced across the system. New Models of Care was about the total span of care - from prevention and self-care through to highly complex care which only a hospital could provide.

The Trust wanted to help people to remain safe and well at home, and preserve their independence and for people approaching end of life to be cared for closer to home if that was their wish. The philosophy was to improve prevention and help people to avoid long-term conditions by changing their lifestyles. This would include earlier, proactive, intervention and less 24-hour care. The aim was to have community-based integrated locality teams which would function as a single team. There was no intention to remove planned or emergency care provision. Step up/step down intermediate care would also be improved.

Dr Tolcher said that the Vanguard Event at the end of May had been excellent and there had been a tremendous response. The intention was now to pick up the threads of the conversation which had been started there and pose two questions - what was your main hope for New Models of Care? And what was your biggest fear for New Models of Care? The answers would be taken away and collated to inform the direction of future policy.

Fifteen minutes was allowed for the conversations before reconvening in plenary session for the Q & A Panel.

Mrs Dodson welcomed Dr Scullion, the Trust's Medical Director and Dr Bruce Willoughby, from the Harrogate and Rural District Clinical Commissioning Group, to the panel and invited questions.

Professor Sue Proctor (Non-Executive Director) said that she had been struck by the point about health and wellbeing, health promotion and lifestyles and wondered about the role of Public Health in New Models of Care.

Dr Willoughby said that this was a good question and one of the main challenges for the locality teams. The intention was to engage with Public Health through the local authority, linking with the prevention agenda, for which NYCC had the lead. The aim was to persuade people to take control of their own health and/or stop it growing worse. Dr Tolcher stressed the importance of early intervention, including pregnancy education, smoking cessation and lifestyle choices. It was important that there was real engagement in the local community and people could be supported to lead good lives.

Mrs Edgar said that this was challenging for staff and how would they be supported to cope. Dr Tolcher replied that that this was fundamental. Staff were motivated and capable and had been involved in the design. In practical terms

more work would take place offsite and there would be more mobile working, supported by the right technologies. Staff would be invited to feed back into the design. New clinical skills and behaviours would be needed and staff would also need to work more in teams. There was transitional funding to cover developmental aspects for staff. Dr Willoughby added that this was about establishing a partnership between patients, staff and the public.

Dr Tolcher said that NYCC had been invited to join the panel but staff illness had intervened but in her view it was about transforming the quality of the relationships between the organisations involved. What was needed was an affordable and balanced health system, which would not be easy to achieve, especially because the local authority and the NHS were very different beasts which were, however, united by the common good.

A member asked about the timeframe for introduction

Dr Tolcher said that the programme was designed to run for three years, which would encompass building the new systems, some double-running whilst they were introduced and then running down the old systems. The first trials would be run in Knaresborough, Green Hammerton and Boroughbridge localities and recruitment was underway. The structure was complex to build and there would be a different story to tell next year.

A member asked whether there were models elsewhere in the world which were wholly or partially built along these lines.

Dr Scullion said that one of the Trust Operational Directors (Mrs Barnett) had recently visited Alaska where a similar and impressive system was in place. Trust was a major factor within the system and such systems would become the norm rather than the exception.

A member commented that some of the statistics did not tell the story about individuals.

Mrs Dodson agreed and said that statistics only told part of the story – the individual and their experience was key. Dr Scullion said that home-delivered care was well-established and did very much place the individual at the centre. It was already delivered and would be developed. Dr Tolcher added that the two commonest reasons for admissions were the requirement for intravenous antibiotics and falls without a fracture and New Models of Care were designed precisely to prevent these having to take place.

Mr Ennis (Stakeholder Governor) said that integration was fundamental and he was very much committed to the new approach, especially with care costs rising to unaffordable levels.

A member commented that the situation in Liverpool was very similar, with social services budgets being cut and the move of care into the home in order to keep people out of hospital.

Dr Willoughby responded that there were financial pressure everywhere and it was important to make use of the freedoms and flexibilities which were available. A workstream was looking at care being delivered in different ways. Patient experience and the quality of care were important, with sustainability in the background. The Vanguard allowed testing of different ways of achieving the best outcome.

In drawing the session to a close Mrs Dodson said that she had been delighted by the evident energy and enthusiasm in the room and how everyone had made a contribution.

6. Presentation on the Annual Report, including the Annual Accounts – Mr Jonathan Coulter, Deputy Chief Executive and Director of Finance

Copies of the Annual Report and Account 2014-15 had been made available to all members attending the meeting.

Mr Coulter repeated the commitment to high quality care and said this went hand in hand with a healthy financial position. He noted that in the 1934 Annual Report of the hospital the average length of stay had been 21 days; nowadays it was somewhat shorter!

The Trust had earned and spent £186.6m in 2014-15 (which equated to £50,000 during the meeting). It had started the year by planning a surplus of £1.8m but had not delivered this, in common with most of the NHS across the country. The current cash balance stood at £4.9m, which would sustain normal operation for a period of ten days. The Trust had derived 95% of its income from treating patients, split approximately 20% in the community and 80% in the acute hospital. A total of 70% of the expenditure had been on staff, of which around £3.8m had been spent on agency and temporary staff. He emphasised that keeping staff would enhance quality of care and also have a financial benefit so reducing the need for agency and temporary staff would have a double benefit.

Moving on to the report of external Auditors, Mr Coulter said that the audit opinion was particularly important and he commended it to members.

Mr Coulter commended the Quality Report, which formed a major part of the Annual Report, and said that this contained fantastic collection of information on quality of care and a myriad other subjects – again he noted the views of the auditors on the content of the Quality Report.

Mr Coulter explained how the Board of Directors acted as the Corporate Trustees for the charitable funds, and explained how these were included in the Annual Accounts. The Auditors had given an opinion which confirmed the accounts as being a true and fair reflection of the evidence they had seen.

Having concluded the formal part of the Annual Report and Accounts, Mr Coulter said that the Trust was under huge pressure and making efficiencies where possible was important. He said that despite external pressures he believed that the Trust had a good grip on the finances but it needed to be brave to empower staff to deliver care in a different way. He quoted Mike Berwick who had said that 'to place the quality and safety of patient care above all other aims was the safest and best way to lower costs'. Harking back to Dr Tolcher's comments, Mr Coulter said that he was a 'glass half full' optimist.

Having received no questions on the Annual Report and Accounts, Mrs Dodson thanked Mr Coulter for his clear presentation.

7. Listening to your feedback – 'the conversation goes on'

Dr Tolcher thanked members for their lively and enthusiastic participation and engagement. The comments which had been made during the 'conversation' would be taken away and shared with the partners in the New Models of Care. She noted that there were more comments on the positive side, which indicated that the Trust should have the confidence to keep going in the intended direction.

As far as hopes were concerned, these included hoping that the money 'worked', better access and outcomes, more patient-centred care and successful partnerships and an even better quality of care.

On the less positive side the fears included whether the communications would work (especially the IT), would there be sufficient funding, and would there be the capacity to build fast and broad across the community. Dr Tolcher commented that the trades unions had been involved and had given their endorsement to the proposed way ahead.

In her view, Dr Tolcher said, it was a case of Bob the Builder's approach – 'yes we can!'

Mrs Dodson thanked those attending for coming and particularly for their engagement. The meeting had been held in a new format which she thought had been successful. However, she would welcome feedback from all those attending on how it had worked for them. She hoped that when the analysis of response had been completed there would be a good balance between hopes and fears. The outcomes would be played into meetings of the Governors and the Board of Directors.

Mrs Dodson then closed the meeting at 8.05pm.

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